



RACE Program Application



Date Submitted: _____

Program Title: Sample Conference

Co-Sponsor Name (if applicable): _____

Provider Name: Sample Provider

RACE-Approved Provider Number: 1234

Contact Person/Program Administrator: Jane Sample

Title: Program Administrator

Phone: 816-931-1504 **Fax:** 816-931-1604

Email Address: race@aavsb.org

Payment Information (review of your program will not begin until payment has been received):

1. Early Program Processing Fee: (46 or more days in advance of first course offering)	\$50.00	<u>50.00</u>
OR	OR	
Late Program Processing Fee: (45 days or less in advance of first course offering)	\$200.00	_____
 PLUS		
2. Per Hour Course Fee:	\$10.00 x <u>38</u> # of hours	<u>380.00</u>
OR	OR	
Large Program Fee (100 or more hours)	\$1000.00	_____
	<u>TOTAL</u>	<u>430.00</u>

Method of Payment:

- Personal check (payable to AAVSB)
- Money order (payable to AAVSB)
- Credit Card

Credit Card Number: _____ - _____ - _____

Expiration Date: Month: _____ Year: _____

Card Holder's Signature: _____

Printed Name: _____

Card Holder's Billing Address: _____

Program Title: Sample Conference

Number of total contact hours of CE available for veterinarians 38
 Number of total contact hours of CE available for veterinary technicians 38
 Maximum # of contact hours of CE for any **ONE** veterinarian (large programs) 19
 Maximum # of contact hours of CE for any **ONE** veterinary technician (large programs) 19

The minimum is 1 hour. Fractions of less than .5 are not permitted.

Method(s) of Delivery:

(check all that apply)

<input checked="" type="checkbox"/>	Classroom
<input type="checkbox"/>	Video/CD/DVD
<input type="checkbox"/>	Correspondence
<input type="checkbox"/>	Online
<input type="checkbox"/>	Lab
<input type="checkbox"/>	Breakfast
<input type="checkbox"/>	Lunch
<input type="checkbox"/>	Dinner
<input type="checkbox"/>	Audio / Teleconference
<input type="checkbox"/>	Satellite / Web Conference
<input type="checkbox"/>	Other (please specify):

Subject Matter Category:

(check all that apply)

<input checked="" type="checkbox"/>	Medical / Surgical
<input checked="" type="checkbox"/>	Practice Management
<input checked="" type="checkbox"/>	Professional Development
<input type="checkbox"/>	Promotional
<input type="checkbox"/>	Acupuncture
<input type="checkbox"/>	Chiropractic
<input type="checkbox"/>	Herbal
<input type="checkbox"/>	Holistic
<input type="checkbox"/>	Equine
<input type="checkbox"/>	Nutritional
<input type="checkbox"/>	Ultrasound
<input type="checkbox"/>	Other:

Location(s):

At **least** one date and location must be listed to process the application:

Locations (City, State)	Date(s)
Kansas City, MO	December 13-15, 2007

By my signature on this Program application, I agree that I have read the standards, applications, and information about the RACE program that are located on the AAVSB website: www.aavsb.org/RACE/RACEHome.aspx; I agree to comply with the Standards for Providers adopted by AAVSB RACE; and I accept responsibility for compliance with the program requirements.

Jane Sample

Signature of Program Administrator

Printed Name:

Date: _____

Title: _____

The Program Application review process takes approximately 3-4 weeks from date of receipt by AAVSB.

Questions? Contact us at (toll-free) 877-698-8482, extension 224, or email RACE@aavsb.org. We look forward to working with you!

