



# Continuing Competency Course Evaluation Request

*Please print all information clearly.*

**Submission Date:** \_\_\_\_\_

**Submitted By:**

**RMTA Member**

Name: \_\_\_\_\_

Association Number: \_\_\_\_\_

Email: \_\_\_\_\_

Telephone Number: (\_\_\_\_\_) \_\_\_\_\_

**Facilitator / Instructor**

Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

\_\_\_\_\_

Email: \_\_\_\_\_

Telephone Number: (\_\_\_\_\_) \_\_\_\_\_

**Course Information:**

Course Name: \_\_\_\_\_

Name of Instructor: \_\_\_\_\_

Course Date (s): \_\_\_\_\_

Course Location (s): \_\_\_\_\_

Registration Information: Email Address: \_\_\_\_\_

Website Address: \_\_\_\_\_

Telephone Number: (\_\_\_\_\_) \_\_\_\_\_

**Documentation Required:**

- Hourly outline of course length, including lunch and breaks for all days
- Detailed outline of course, including what the participants are taught, what they will learn, clinical skills after completion, and any additional skills learned throughout the course
- Instructor biography / CV that clearly outlines expertise and education to adequately teach this course
- Course description (maximum 500 words) for public posting on website

**Comments for Course Consideration:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

<b><u>RMTA Use Only</u></b>
Date Approved: _____
Name of Evaluator: _____
Contact Hours: _____
Approved Credits: _____
<input type="checkbox"/> Primary
<input type="checkbox"/> Secondary
<input type="checkbox"/> Personal Development