State of California

Department of Insurance

Class Presentation Schedule

LIC 446-12 (Rev 12/2008)

Curriculum and Officer Review Bureau - Education Unit
300 Capitol Mall
Sacramento, CA 95814-4344
Information (916) 492-3064
www.insurance.ca.gov

Instructions:

- Type or print clearly. **USE A SEPARATE SHEET FOR EACH CLASS PRESENTATION.**
- To inform the Department of a new class, mark NEW box and provide all pertinent information below.
- To notify the Department of a change to a class schedule previously submitted, mark CHANGE, give the original date, time, location and provide new information below.
- To cancel a class previously submitted, mark CANCEL and complete information below.
- Completed form must be received by the Department at least 14 days prior to the original class presentation. Subsequent presentations must be received at least 10 days prior to class presentation. No faxes will be accepted.
- Late schedules may not be accepted and attendees may not receive continuing education credit.
- The information provided below must match the information on the certificate of completion and the provider roster.

CHECK ONE: **New** ☐ **Cancel** ☐ **Change** ☐

In-House Offering ☐
(If marked this will not show on Department's website Provider and Course Search.)

Original Date/Time:
Original Location:
Combination Course ☐

Provider ID #:
Provider Name

Course ID#:	Credit Hours:	Instructor Name:	
Course Name:			
Start Date*:	Start Time:	End Date:	End Time:

Military Time **Military Time**

*If course spans more than one day, each day must be listed in Daily Presentation Schedule chart below.

Location of Presentation:

Street:	Room/Suite:	
City:	State:	Zip:

Daily Presentation Schedule: **Times must be shown in military time (i.e. 8:00 AM = 0800; 2:00 PM = 1400)**

Day	Date: (month/day/year)	Begin Time	End Time
Day 1			
Day 2			
Day 3			
Day 4			
Day 5			
Day 6			
Day 7			

(Attach sheet for additional days)

I certify that the class information provided here is true and correct to the best of my knowledge. Any changes will be provided to the Department promptly.

Original Signature of Provider Director Date

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Printed Name of Provider Director Phone Number