State of California
Prelicensing/Continuing Education Program
Provider Roster
LIC 446-13 (Rev. 1/2023)

Department of Insurance

Curriculum and Officer Review Bureau – Education Unit
300 CAPITOL MALL
SACRAMENTO, CA 95814-4349
Information (916) 492-3064
www.insurance.ca.gov

Important: This form must be submitted to the Commissioner within 10 days following the completion of the prelicensing course and 30 days follows the completion of the continuing education course.

Items marked with an asterisk (*) are not required for non-contact courses.

Late rosters may not be accepted.

Pre-licensing Course: ☐ Continuing Education Course: ☐
Contact course: ☐ Non-Contact course: ☐ Combination Course: ☐

Provider ID #: _____ Provider Name: _____

Course ID #: _____ Credit Hours: _____ Course Name: _____

*Course Start Date: _____ *Beginning Time: _____ *End Time: _____ Completion Date: _____
(***Military time (i.e. 1300 = 1:00 P.M.)**

*Class location: _____
Street Address Suite/Room,

_____
City State Zip Code

The Commissioner requests disclosure of a student's last four digits of his or her social security number and the student's birth date shown as month, day, and year (mm/dd/yyyy) pursuant to Insurance Code Sections 1749, 1749.2, 1749.3, 1749.4, 1749.5, and 1749.7, and California Code of Regulations, Title 10, Chapter 5, Sections 2188.4(b) and 2188.5(b)(1). This information will enable the Commissioner to properly identify and assign credit to students who have completed a prelicensing course. For continuing education courses, the student's insurance license number is required. While a student's disclosure of his or her full birth date and the last four digits of his or her social security number are not mandatory, any failure to provide this information may delay or otherwise impede the Commissioner in assigning credit for the completion of such courses to the appropriate students.

ALL ENTRIES MUST BE TYPED. #				
#	Last Four Digits of the Social Security Number	Student's Name: Last First M.I.	Birth Date (mm/dd/yyyy)	Individual Insurance License Number
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				

10.				
11.				
12.				

Certification

I have reviewed this Provider Roster and the associated Course Attendance Records or examination information and certify to the best of my knowledge that the individuals listed here meet the requirements for credit.

► _____ _____ (____) _____

Original signature of Provider Director Date Telephone

_____

Printed Name of Provider Director