



NEW YORK STATE
DEPARTMENT OF FINANCIAL SERVICES
LICENSING SERVICES BUREAU
 Continuing Education Program
 One Commerce Plaza
 Albany, New York 12257

FOR DEPARTMENT USE ONLY Examined By: _____ Date Examined: _____
--

MONITOR ORGANIZATION / PROVIDER MONITOR DESIGNATED PERSON NOTICE

To change the name and/or contact information of a Designated Person complete the following.

Name of Monitor Organization or Provider Monitor		Monitor Approval Number		
Headquarters Address of Monitor	City	County (NY only)	State	Zip Code
*Name of Designated Person: Last First Middle	Title		Date of Designation	
Business Address of Designated Person <input type="checkbox"/> Same as above	City	County (NY only)	State	Zip Code

*There may be only one designated person for the Monitor Organization/Provider Monitor

To terminate a Designated Person complete the following:

Name of Designated Person to be terminated: Last First Middle	Date Terminated
--	-----------------

RESPONSIBILITIES OF A DESIGNATED PERSON

1. Assures that submissions to this Department are timely and in accordance with Department criteria.
2. Assures that the examination is administered in accordance with the Course Approval issued by the Department
3. Assures that only approved manuals or schedules necessary for completion of the examination are used during the exam
4. Assures that the examination is forwarded with the appropriate documents to the Provider Organization for scoring.
5. Is available to this Department on a daily basis, a Designated Person must be able to communicate with this Department when issues arise and be given the authority to resolve Department concerns.

I have read the responsibilities of the Designated Person and will comply.

Signature of Designated Person Being Appointed

Date

Type or Print Above Name

Telephone Number

Email Address

Fax Number

Website Address of Monitor or Provider Monitor(www.)

The remainder of this form must be completed by the Monitor Organization / Provider Monitor.

The Monitor Organization / Provider Monitor must immediately notify this Department of any changes in any Designated Person.

I verify that the Monitor Organization / Provider Monitor has satisfied itself as to the validity of the information on this form.

Signature of Officer, Director or Partner of
Monitor Organization/Provider Monitor

Date

Type or Print Above Name

Title