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:___________

C.E. PROVIDER ORGANIZATION DESIGNATED PERSON NOTICE

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

Name of Provider Organization			Provider Organization Approval Number		
Headquarters Address of Provider Organization	City		County (NY only)	State	Zip Code
*Name of Primary Designated Person: Last First Middle	Title		Date of Designation		
Business Address of Designated Person ☐ Same as Headquarters	City		County (NY only)	State	Zip Code
*Name of Secondary Designated Person: Last First Middle	Title		Date of Designation		
Business Address of Designated Person ☐ Same as Headquarters	City		County (NY only)	State	Zip Code
*Name of Secondary Designated Person: Last First Middle	Title		Date of Designation		
Business Address of Designated Person ☐ Same as Headquarters	City		County (NY only)	State	Zip Code

*May appoint only one Designated Person as the Primary Designate. A Designated Person must be accessible to this Department on a daily basis, be able to communicate with us when issues arise, and be given the authority to resolve Department concerns.

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. Assure that submissions to this Department are timely and in accordance with Department criteria.
2. Resolve any issues regarding courses offered under the auspices of the Provider Organization.
3. Assure that the administration of the Provider Organization's Continuing Education Program and the maintenance of records are in compliance with Department requirements.
4. Be available to this Department on a daily basis and to be given the authority to resolve Department concerns.
5. Report licensee course completion electronically to this Department in accordance with Department Criteria.

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**

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

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

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

Signature of Officer, Director, Member or Partner of Provider Organization	**Date**
Type or Print Above Name	**Title**