## CPD Provider Registration Form

To provide content under Category A and award CEUs to health professionals, CPD providers must have an active registration with each applicable board. To register, complete and submit this form annually, along with the corresponding registration fee.

**Form Submission**

To submit the form, there are two options:

1. Submit the digital form via the board’s website. If registering with multiple boards, you will need to submit the digital form on all applicable websites.
2. Fill in this Word Document and email it to all applicable boards using the contact information below:

BALMLT: [balmlt.liberia@gmail.com](mailto:balmlt.liberia@gmail.com)

LBNM: [nursingboardlib@gmail.com](mailto:nursingboardlib@gmail.com)

LMDC: [lmdc.lib@gmail.com](mailto:lmdc.lib@gmail.com) / [info@liberiamedicaldentalcouncil.gov.lr](mailto:info@liberiamedicaldentalcouncil.gov.lr)

LINPAB: [linpab1998@gmail.com](mailto:linpab1998@gmail.com)

LPB: [pharmacyboardliberia@yahoo.com](mailto:pharmacyboardliberia@yahoo.com)

LEHP: [lapht63@gmail.com](mailto:lapht63@gmail.com) / [info@liberiaenvironmentalhealthboard.org](mailto:info@liberiaenvironmentalhealthboard.org)

**Registration Fee**

First, confirm the required fee based on your organization’s profile and whether you will be collecting course fees from participants:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **CPD Provider Organizational Registration** | **Organization Characteristics** | **Course Fees** | **Annual Registration Fee in USD\* for**  **1 Board** | **Annual Registration Fee in USD\* for**  **2+ Boards** |
| In Liberia | MOH or other GOL | Free or participants pay | $50 | $25 per board ($150 for all 6) |
| Health Professions Associations | Free or participants pay |
| Organizations <20 employees | Free or participants pay |
| 20+ employees | Free | $100 | $50 per board  ($300 for all 6) |
| Participants pay | $150 | $75 per board  ($450 for all 6) |
| Outside of Liberia | Any | Free or participants pay | $300 | $150 per board  ($900 for all 6) |

Second, make the appropriate payment to each applicable board using the payment instructions below:

BALMLT:

1. Deposit funds to LBDI account 00240815342102 (Liberia Association of Medical Laboratory Technologists). Note that this is a USD account.
2. Scan the deposit slip and email to [balmlt.liberia@gmail.com](mailto:balmlt.liberia@gmail.com)

LBNM:

Payment information will be provided after submission of registration form.

LMDC:

1. Deposit funds to one of the below accounts:
   1. USD: Ecobank account 6100048932
   2. LRD: Ecobank account 6101347331
2. Scan the deposit slip and email to [lmdc.lib@gmail.com](mailto:lmdc.lib@gmail.com) / [info@liberiamedicaldentalcouncil.gov.lr](mailto:info@liberiamedicaldentalcouncil.gov.lr).

LINPAB:

1. Deposit funds to one of the below accounts:
   1. USD: LBDI account 002USD-40-411604302 (LINPAA Project Account)
   2. LRD: LBDI account 002LRD-40-411604301 (Liberia National Physician Assistant Account)
2. Scan the deposit slip and email to [linpab1998@gmail.com](mailto:linpab1998@gmail.com).

LPB:

1. Deposit funds to one of the below accounts:
   1. USD: LBDI account 002USD21211060702 (Pharmacy Board of Liberia)
   2. LRD: LBDI account 002LRD21211060701 (Pharmacy Board of Liberia)
2. Scan the deposit slip and email to [linpab1998@gmail.com](mailto:linpab1998@gmail.com).

LEHB:

1. Deposit funds to Ecobank account 6100200422 (Liberia Association of Public Health Technician). Note that this is a USD account.
2. Scan the deposit slip and email to [lapht63@gmail.com](mailto:lapht63@gmail.com) OR proceed to the finance officer of the Association at New Matadi with a copy of the deposit slip to obtain official receipt..

**Part 1: CPD Provider Information**

|  |  |
| --- | --- |
| **Name of CPD Provider** |  |
| **Contact Person** |  |
| **Job Title of Contact Person** |  |
| **Phone Number of Contact Person** |  |
| **Email Address of Contact Person** |  |
| **Physical Address of Contact Person** |  |
| **Website** |  |
| **If outside of Liberia, name of partner organization in Liberia** |  |
| **In which counties do you plan to provide CPD?** |  |

**Which term best describes your organization?**

*Place an “X” next to the appropriate category.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | *Health Association* |  | *Training Institution* |  | *Government Ministry* |
|  | *Business* |  | *International NGO* |  | *Community-Based Organization* |
|  | *Health Facility* |  | *Other, please describe:* |  | |

**Part 2: Registration Election**

*Place an “X” next to all that apply.*

|  |  |  |
| --- | --- | --- |
| **Board** | **Included Cadres** | **Tick if Registering** |
| LMDC | GP, Specialist, Paramedic, Dentist |  |
| LBNM | Registered Nurse, Nurse Anesthetist, Ophthalmic Nurse, Nurse Educator, Mental Health Nurse, Nurse-Midwife, Certified Midwife, Registered Midwife |  |
| LPB | Pharmacy Dispensers, Pharmacy Technicians, Pharmacists, GP, Specialist |  |
| LINPAB | Physician Assistant |  |
| BALMLT | Laboratory Assistant, Laboratory Technicians, Laboratory Technologists/Scientists, Laboratory Specialists |  |
| LEHB | Public Health Technicians, Environmental Health Technicians |  |

**Part 3: Appendix**

*Please submit the following along with your CPD Provider Registration Form:*

* [Required] Business registration or equivalent documentation (e.g. Council of Higher Education accreditation, MOH Sectoral Clearance, articles of incorporation, etc.). For organizations outside of Liberia, include documentation for both the CPD provider and partner organization in Liberia.
* [Optional] Training plan, including course topics and description of target audience
* [Optional] For registration renewals, reports or evaluations from previously-delivered CPD courses

**Part 4: Decision (to be completed by relevant board or boards)**

|  |  |
| --- | --- |
| **Reviewer Name** |  |
| **Date Reviewed** |  |

**Recommendation**

*Place an “X” next to the decision.*

|  |  |
| --- | --- |
| **Accepted** |  |
| **Rejected** |  |

**If accepted, CPD Provider number:**

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| --- |
|  |

**If rejected, provide justification:**

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