



ICEA RETROACTIVE CONTACT HOUR APPLICATION

Name _____ ICEA member number _____

Address _____

Email address _____

Program name _____

Program sponsor _____

Program date and location _____

Number of contact hours you are applying for _____

1. _____ One copy of completed application page.
2. _____ One copy of event schedule or agenda (must include listing of presentation times, including meals and breaks).
3. _____ One copy of certificate of attendance.
4. _____ One copy of your description of reasons why you believe this program should be awarded retroactive hours. Give evidence that it supports ICEA's mission, "freedom of choice based on knowledge of alternatives in family-centered maternity and newborn care."
5. _____ \$25 (US) for retroactive contact hour application fee.

Payment in US funds, check and drafts drawn on US banks only or Visa or MasterCard.

Visa/MasterCard number _____ Expiration date _____

Signature _____ Security Code _____

NOTE: ICEA will return all incomplete applications.

Send all of the above to: ICEA Central Office
Box 20048
Minneapolis, Minnesota 55420 USA