

CERTIFIED PROVIDER: SIX MONTH CE ACTIVITY REPORT

Due to WVBSWE Office: **DUE: January 15th: for events held from July 1st – December 31st DUE: July 15th: for events held from January 1st – June 30th of each year**
Complete and Mail To: CEC-WVBSWE-PO BOX 5459-CHARLESTON, WV 25361 Every Six Months by Jan 15th and July 15th

For period of: Month: _____ Year: _____ **Through:** Month: _____ Year: _____ **DATE SUBMITTED TO WVBSWE:** _____

This report must be submitted every six months as required for recertification provisions. The document shall be reviewed by the designated responsible Licensed Social Worker for accuracy prior to submission.

Certified Provider Name: _____ WVBSWE Assigned Provider Number: _____

Provider Address: _____ Phone Number: _____

Name of Responsible BSW/MSW Social Worker: _____ Contact Person: _____

EVENT TITLE	DATE(S)	#HOURS	LOCATION (CITY)	NAME/CREDENTIAL OF PRESENTER	OPEN YES/NO

