



**NEW YORK STATE INSURANCE DEPARTMENT  
LICENSING SERVICES BUREAU**

**Continuing Education Program**

For Department Use Only

One Commerce Plaza  
Albany, New York 12257

Approval No.: _____
Examined by: _____
Approved Date: _____

**DESIGNATED PERSON NOTICE**

(Complete and submit to add, terminate or change a Designated Person)

Name of Provider Organization				Provider Organization Approval Number		
Designated Person: Last	First	Middle	Title	Date of Designation	Telephone Number	

If this Designated Person is replacing another complete the following:

Designated Person to be terminated: Last	First	Middle	Date Terminated

**RESPONSIBILITIES OF A DESIGNATED PERSON**

1. To assure that submissions to this Department are timely and in accordance with Department criteria;
2. To resolve any issues regarding courses offered under the auspices of the Provider Organization;
3. To assure that the administration of the Provider Organization's Continuing Education Program and the maintenance of records are in compliance with Department requirements;
4. To be available to this Department on a daily basis and to 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**

\_\_\_\_\_  
**Title**

\_\_\_\_\_  
**Email Address**

\_\_\_\_\_  
**Fax Number**

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

\_\_\_\_\_  
**Signature of Officer, Director or Partner of Provider Organization**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Type or Print Above Name**

\_\_\_\_\_  
**Title**