



STATE OF NEW MEXICO
OFFICE OF SUPERINTENDENT OF INSURANCE
Continuing Education Instructor Application

Application must be filled out completely
All fields are required unless specified

Provider Information

Provider Name:	Provider NM Number:	
I attest that the information on this form is true and correct to the best of my knowledge. It accurately represents at least the minimum qualifications required to be met by the individual named on this form as an instructor. Further, the individual named as an instructor has been approved by this Provider.		
Print/Type Name of Provider Representative	Signature	Date
_____	_____	_____
Title/NPN (if applicable)	Provider Phone #	Provider Email
_____	() _____	_____

Instructor Contact Information

Instructor Last Name	First Name	Middle Initial
_____	_____	_____
Mailing Address Line 1		Mailing Address Line 2 (Apt., Unit, Bldg.)
_____	_____	
City	State	Zip Code
_____	_____	_____
Phone Number		Ext.
() _____		_____

Instructor Requirements

Have you ever been licensed under a different name? If so, please enter information below. Enter N/A if not applicable.

Last, First Name	Instructor ID	NPN	State
_____	_____	_____	_____
Instructor Qualifications - Instructor must meet the requirements below. Please select all that apply Qualified instructor – per 13.4.7.7 S. means a person who has demonstrated competency in the subject matter of an approved course through one of the following means: • a college degree from an accredited institution of higher learning with a major in • insurance; • a professional designation of CLU or CPCU or similar designation from an industry association; • three or more years of practical experience in the subject matter being taught or monitored • a qualified instructor shall not have been subject to any order of revocation, suspension, or other formal disciplinary action in any state;			



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Instructor Acknowledgement

*I attest that the information on this form is true and correct to the best of my knowledge and the information accurately represents my qualifications to teach insurance courses. **I have not been subject to any order of revocation, suspension, or other formal disciplinary action in any state**; I understand the information on this form is subject to verification through the audit process. I agree to abide by all NM OSI statutes, regulations, and program requirements regarding insurance and insurance continuing education.*

Print/Type Name of Instructor

Signature

Date

Office use only

Completed Date: _____

Notification Date: _____

Processor Initials: _____