New York State
Department of State
Division of Licensing Services
Bureau of Educational Standards
P.O. Box 22001
Albany, NY 12201-2001
(518) 486-3803
https://dos.ny.gov

Bail Enforcement Qualifying Course Approval Renewal Application

PLEASE READ CAREFULLY, AS INCOMPLETE APPLICATIONS WILL BE RETURNED.

» The non-refundable fee of **$25** must accompany this original, signed application (photocopies will not be accepted). Fees may be paid by check or money order (made payable to the Department of State) or by MasterCard or Visa, using a credit card authorization form. Do not send cash.
» A non-refundable fee of **$25** must be submitted for each additional location.
» Annual registration period runs from January 1st through December 31st.
» All instructors must be approved.

PLEASE INDICATE THE TYPE OF COURSE:

[ ] Classroom Instruction   [ ] Live Distance Education (Synchronous with Instructor)

Please indicate the course code number

For the course you want to register . . . . . CODE # E _____

SCHOOL NAME
_____

ADDRESS (NUMBER AND STREET; ROOM/SUITE DESIGNATION)
_____

CITY	STATE	ZIP+4

E-MAIL ADDRESS (IF ANY)
_____

PRIMARY LOCATION (PLACE, NUMBER AND STREET; ROOM/FLOOR/SUITE DESIGNATION)
_____

CITY	STATE	ZIP+4

CLASSROOM COURSES ONLY SECONDARY LOCATION #1   (PLACE, NUMBER AND STREET; ROOM/FLOOR/SUITE DESIGNATION)
_____

CITY	STATE	ZIP+4

SECONDARY LOCATION #2   (PLACE, NUMBER AND STREET; ROOM/FLOOR/SUITE DESIGNATION)
_____

CITY	STATE	ZIP+4

SECONDARY LOCATION #3   (PLACE, NUMBER AND STREET; ROOM/FLOOR/SUITE DESIGNATION)
_____

CITY	STATE	ZIP+4

1. Is any change being made to the course delivery method?   Yes*   No

   If Yes*, attach a description of design and delivery format (Section 159.1).

Indicate names and signatures of persons authorized to sign course completion certificates:

PRINT NAME
_____

SIGNATURE OF COORDINATOR
_____

SIGNATURE
_____

( )
BUSINESS PHONE NUMBER

PRINT NAME
_____

E-MAIL ADDRESS (if any)
_____

SIGNATURE
_____

DATE

FOR OFFICE USE ONLY   EFFECTIVE DATE: ___/___/___   EXPIRATION DATE: ___/___/___   ENTERED: ___/___/___   BY: _____   LABEL [   ]

FEE RECEIVED: _____   TO REVENUE: ___/___/___   APPROVAL MAILED: ___/___/___   RECEIPT #: _____

A fee of $20 will be charged for any check returned by a bank for insufficient funds.