## BOC Continuing Education Reporting Form (Due by 12/31/2021)

• Record only activities for the continuing education (CE) accumulation period ending 12/31/2021 •

If you choose NOT to submit your CE online using BOC Central™ at BOCATC.org, submit this completed reporting sheet with credit card information via fax to (402) 561-0598 or mail it to the address below along with a \$25 check or money order made payable to the BOC.

Board of Certification Attn: CE Reporting 1415 Harney St, Ste 200 Omaha, NE 68102-2250 NOTE: The BOC requests paper CE submissions be postmarked by December 1, 2021 of the reporting year to allow time for processing by the December 31, 2021 deadline.

Total continuing education units (CEUs) due can be found on your BOC Central™ profile. 2020-2021 "Certification Maintenance Requirements" are available at BOCATC.org. 9 or 10-digit BOC Certification #: \_\_\_\_\_\_ Name: \_\_\_\_\_\_Name: Phone #: \_\_\_\_\_ Address: \_\_\_\_ \_\_\_\_\_ City/State/ZIP: \_\_\_\_ Email Address: Are you actively engaged in patient care as an Athletic Trainer? O Yes - Full Time O Yes - Part Time O Yes - Per Diem/PRN ○ No – I am not engaged in patient care ○ No – I am engaged in patient care using a different credential (see below) Select other health care credential(s) you hold: DC DDS EMT MD/DO OTO TOTA PA PT PTA RN Other No other health care credentials Do you hold an active Athletic Trainer license to practice in your state? O Yes O No Payment Information - \$25 Processing Fee Visa, MasterCard, American Express, Discover or Check/Money Order (made payable to BOC) Account #: \_\_\_\_\_ CVV Code: \_\_\_\_\_ Expiration Date: \_\_\_\_\_ Name on Account:\_\_\_\_\_\_ Billing Address:\_\_\_\_\_ Signature: \_\_\_\_\_ City/State/ZIP: \_\_\_\_\_ • ATs with 50 CEUs due must complete at least 10 EBP CEUs Level I – EBP Category: BOC Approved EBP Programs ATs with 25 CEUs due must complete at least 5 EBP CEUs **Earned Date** Provider # Name of Provider/Institution/Journal **Activity Title** # of CEUs (mm/dd/yyyy) Level I - Category A: BOC Approved Provider Programs **Earned Date Activity Title** Provider # # of CEUs **Provider Name** (mm/dd/yyyy)

Level II – Category B: Professional and Scholarly Activities									
Earned Date (mm/dd/yyyy)	Activity Type				Ti	tle of Publication/Textk	# of CEUs		
Level II – Category C: Post Certification College/University Coursework									
Earned Date (mm/dd/yyyy) Course			urse Title			College/University		Credit Hours	# of CEUs
Level II – Category D: Non-Approved Provider Programs									
Earned Date (mm/dd/yyyy)	Activity Type				Activity Title				# of CEUs
Total CEUs									
EBP		Cotog	on. A	Category	D	Category C	Catag	ony D	GRAND TOTAL
EDP		Category A		Category	Ь	Category	Category D		GRAND TOTAL
Emergency Cardiac Care (ECC)									
Farned Date Evn Date									
(mm/dd/yyyy)									
Please check the appropriate box:  I have maintained ongoing certification in ECC for this reporting period and possess documentation for all ECC entries listed above.  I have not maintained ongoing certification in ECC for this reporting period, or I no longer possess documentation for all ECC entries listed above.  If audited, I am aware that I may be required to provide a written explanation if my ECC certification lapsed during any portion of this reporting period or I am unable to provide documentation of ECC certification.									
Certification Maintenance Confirmation Statements (all boxes must be checked for form to be proc									rm to be processed
The information contained in this report is a true and accurate statement of my continuing education activities.									
I am submitting no less than the minimum number of CEUs required for the current reporting period, including the required EBP Category CEUs.									
☐ I am in possession of and prepared to present all original documentation confirming participation in reported activities. I am aware I must keep these records for at least two years after the reporting period has ended.									
☐ I have conducted myself as a Certified Athletic Trainer in accordance with the "BOC Standards of Professional Practice."									
I am aware that I am required to maintain ongoing certification in emergency cardiac care throughout the reporting period and I must keep these records for at least two years after the reporting period has ended.									
☐ I have paid or will pay the 2020 and 2021 certification maintenance fees by 12/31/2021.									
I am aware that the BOC reserves the right to audit me at any time and that failure to comply with BOC audit policies may result in the suspension of my BOC certification.									
I am aware that I will be subject to an audit if this form is received after the 12/31/2021 deadline.									
I am aware that my name, location and certification status, certification number and expiration date will be available online through the BOC certification verification system to potential employers, state licensing officials and others.									
☐ I am aware	that falsificat	tion of this	s report may ı	result in the suspe	ension of	my BOC certification.			
Signature:Date:									