



NEW YORK STATE
DEPARTMENT OF FINANCIAL SERVICES
INSURANCE LICENSING SERVICES BUREAU
 Prelicensing Education Program
 One Commerce Plaza
 Albany, New York 12257

FOR DEPARTMENT USE ONLY Examined By: _____ Date Examined: _____
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PROVIDER ORGANIZATION DESIGNATED PERSON NOTICE

To add or change the name and/or contact information of a Designated Person complete the following.

Name of Provider Organization		Provider Organization School Code		
Headquarters Address of Provider Organization	City	County (NY only)	State	Zip Code
*Name of Primary Designated Person: Last First Middle	Title		Date of Designation	
Business Address of Designated Person <input type="checkbox"/> Same as Headquarters	City	County (NY only)	State	Zip Code
*Name of Secondary Designated Person: Last First Middle	Title		Date of Designation	
Business Address of Designated Person <input type="checkbox"/> Same as Headquarters	City	County (NY only)	State	Zip Code
*Name of Secondary Designated Person: Last First Middle	Title		Date of Designation	
Business Address of Designated Person <input type="checkbox"/> Same as Headquarters	City	County (NY only)	State	Zip Code

*May appoint only one Designated Person as the Primary

To terminate a Designated Person complete the following:

Name of Designated Person to be terminated: Last First Middle	Date Terminated
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RESPONSIBILITIES OF A DESIGNATED PERSON

1. Assure that submissions to this Department are timely and in accordance with Department criteria.
2. Resolve any issues regarding courses offered under the auspices of the Provider Organization.
3. Assure that the administration of the Provider Organization's Prelicensing Education Program and the maintenance of records are in compliance with Department requirements.
4. 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

Telephone Number

Email Address

Fax Number

The remainder of this form must be completed by the Provider Organization.

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

I verify that the Provider Organization has satisfied itself as to the validity of the information on this form.

**Signature of Officer, Director or Partner of
Provider/Monitor Organization**

Date

Type or Print Above Name

Title