



Provider Name ①

CERTIFICATE OF COMPLETION

This is to certify that

Participant Name ②

Attended the Live Continuing Education Program

Program Title ③

on

Completion Date ④

_____ **Credit Hours** ⑤

⑦ *Signature* _____

Name of the Provider's Authorized Representative

Title of the Provider's Authorized Representative

⑥ **NBCC Approval No. SP-** _____

Provider's contact information ⑧

