

# CERTIFICATE OF COMPLETION

## Medication Administration: 15-Hour Training Course for Adult Care Homes

*This is to certify that*

\_\_\_\_\_  
Name of Student

*has successfully completed the above North Carolina  
State-approved Medication Administration Training Program  
at*

\_\_\_\_\_  
Name of Training Location (school, facility, etc.)

*on the* \_\_\_\_\_ *day of* \_\_\_\_\_, 20\_\_\_\_.

**Certified by:**

\_\_\_\_\_  
Print Name of Trainer

\_\_\_\_\_  
Employed by

\_\_\_\_\_  
Signature of Trainer (include licensing credentials)

\_\_\_\_\_  
Date