

CERTIFICATE OF COMPLETION

Medication Administration: 5-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