CERTIFICATE OF COMPLETION

Medication Administration: 10-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