

# **Name of Organization**

Organization Address, City, State, and Zip

## **Certificate of Attendance**

**Presented To:**

\_\_\_\_\_

**For Successfully Completing the Continuing Nursing Education Activity**

**Name/Title of Program**

**Date(s) of Program**

\_\_\_\_ **Contact Hours**

**Signed** \_\_\_\_\_

**This continuing nursing education activity was approved by the South Carolina Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation. Approval valid through (insert expiration date).**