[Name of Approved Provider]

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

[Name of approved provider] is an approved provider of continuing nursing education by the South Carolina Nurses Association an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

SAMPLE