

CERTIFICATE OF COMPLETION

Medication Administration: 10-Hour Training Course for Adult Care Homes

This is to certify that

Name of Student

*has successfully completed a 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 (including licensing credentials)

Date