**Activity Sample Certificate**

Organization Name   
Address / City / State / Zip  
( or website address)

(Name of Participant)

has successfully completed

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
(activity title)

Date: Contact Hours Awarded:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorized Signature   
*(no longer required)*

[Name of Approved Provider] is approved as a provider of nursing continuing professional development by Connecticut Nurses' Association, an accredited approver by the American Nurses Credentialing Center’s Commission on Accreditation.