













































Insert Designated Provider Agency  
Logo Here

Participant's Name:

Participant's Email Address:

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**INSERT DESIGNATED PROVIDER AGENCY NAME**

Insert Designated Provider Agency Address

**CERTIFICATE OF CONTINUING EDUCATION**

**Title of CE Offering:**

**Location (City, State):**

**Date(s):**

This signed Certificate of Continuing Education Hours affirms that the individual name above attended this continuing education activity endorsed by *(Insert Designated Provider Agency Name Here)*.

This activity, for *(insert number of CE hours received by the participant)* hour(s) of CE hours for full attendance/successful completion, has been awarded by *(insert agency name)* which is a designated provider of continuing education for the DMH *(insert name of credentialing program)*.

The CE evaluation form for each session was handed out at the end of the session. All signed and submitted participant evaluation forms have been cross-referenced against the certificate of continuing education issued. Participant evaluations must be received in order to receive credit. This is a certified form confirming the number of CE hours earned by the participant.

\_\_\_\_\_  
*Signature of Designated Provider Agency  
Representative with title*

\_\_\_\_\_  
Date of Approval

***Any dispute regarding CE hours must be made to the Designated Provider Agency within 90 days of the CE offering.***