***REPLACE THIS TEXT WITH THE LOGO OF ORGANIZATION PROVIDING EDUCATION***

Provider Address:

Provider Web Address:

**Certificate of Completion**

**Approved Nursing Continuing**

**Professional Development Activity**

**NAME:**

**Program Title**:

**Program Type (Live/Enduring):**

**Program Location**:

**Activity Date(s):**

**Contact Hours**:

*This nursing continuing professional development activity was approved by the International Association of Forensic Nurses, an accredited approver by the American Nurses Credentialing Center’s Commission on Accreditation.*