***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**: <Insert Program name, if applicable> Pediatric/Adolescent Sexual Assault Nurse Examiner Training Program

**Program Type:** Live Training

**Program Location**: Venue name, venue city, venue state

# Date:

**Contact Hours**: 40

*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.*

International Association of Forensic Nurses 2024