

Name of Your Agency/Organization/Program

Certificate of Completion

This is to document that

Name of Recipient

has s*uccessfully completed* the  **12 -**Hour curriculum requirement for

Medication Assistant Certification (MAC-1)

*with a* ***passing score*** on: \_\_\_\_\_\_\_\_\_\_\_ at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Date Name/Location of Facility*

*Presented By: , RN or LPN*

 *Signature of MAS Certifying Nurse/ Instructor*

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

 Signature of Participant