CERTIFICATE OF CONTINUING EDUCATION

Name (Please Print):_________________________________ Middle Initial_______________
License No.: ____________________ (State, if different than Iowa: ___________________)
Home Address ____
City: ________________________ State: ____________________ Zip: ________________
Department or Place of Employment: ____

All information must be complete and legible for record to be processed and retained

Date:____________________________________ (July 1, 2020 through June 30, 2021)

Program Title: Iowa Workers' Compensation Advisory Committee Web-osium

Subtitle:

Contact Hours Earned: 1 contact hours **(NO PARTIAL CREDIT WILL BE GIVEN)**

Iowa Board of Nursing has approved MercyOne Des Moines Medical Center as Provider #17.

Top Copy – The licensee must retain this certificate for four (4) years after the course offering.
Bottom Copy – Return to Nursing Education

Rev. 7/2020

PARTICIPANT COPY

CERTIFICATE OF CONTINUING EDUCATION

Name (Please Print):_________________________________ Middle Initial_______________
License No.: ____________________ (State, if different than Iowa: ___________________)
Home Address ____
City: ________________________ State: ____________________ Zip: ________________
Department or Place of Employment: ____

All information must be complete and legible for record to be processed and retained

Date:____________________________________ (July 1, 2020 through June 30, 2021)

Program Title: Iowa Workers' Compensation Advisory Committee Web-osium

Subtitle:

Contact Hours Earned: 1 contact hours **(NO PARTIAL CREDIT WILL BE GIVEN)**

Iowa Board of Nursing has approved MercyOne Des Moines Medical Center as Provider #17.

Top Copy – The licensee must retain this certificate for four (4) years after the course offering.
Bottom Copy – Return to Nursing Education

Rev. 7/2020

RETURN TO PROGRAM PLANNER AT END OF PROGRAM