

# Arkansas Department of Health

This is to certify that

\_\_\_\_\_ has successfully completed

Course Name: \_\_\_\_\_

Course Hours: \_\_\_\_\_

\_\_\_\_\_  
Signature of Emergency Medical Service Provider

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Instructor

\_\_\_\_\_  
Course ID

\_\_\_\_\_  
Date

