

XYZ Organization
XYZ Organization Street Address
XYZ Organization City, State, and Zip

Title of Program:

[Title]

Dates and Location:

[Date]
[Location]

Approval Statement:

This continuing nursing education activity was approved by the Wisconsin Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

Participant's Name and Address: (please print)

Name: _____

Address: _____

Personal Verification of Attendance:

I verify that I attended and completed an evaluation for each session indicated and therefore have earned the number of contact hours totaled.

Signature: _____

 Nancy Nurse, 2009 Pediatric Diabetes Conference
 Planning Committee

_____ (Participant's name) is awarded up to 6.5 contact hours for participation in and successful completion of the following sessions of the educational activity:

[Date]			
Time	Session	Contact Hours	Total
9:00 AM	Keynote <i>[Presenter Name and Credentials]</i> <i>[Presenter Title]</i>	1.0	_____
10:45 AM	Breakout Session #1 (1A-1E) Indicate session: _____	1.25	_____
3:15 PM	Breakout Session #2 (2A-2E) Indicate letter: _____	1.25	_____
[Date]			
8:30 AM	Plenary Session: <i>[Presenter Name and Credentials]</i>	1.0	_____
9:45 AM	Breakout Session #3 (3A-3C) Indicate letter: _____	1.25	_____
11:15 AM	Plenary Session: <i>[Presenter Name and Credentials]</i>	.75	_____
TOTAL CONTACT HOURS		6.5	_____

Please return the bottom copy of this certificate to the Registration Desk and retain the top copy for your records.

Thank you for attending the 2009 Pediatric Diabetes Conference!

*Please join us next year for the
 2010 Pediatric Diabetes Conference
 November 16, 2010, Lake Wichita, MD*