

NURSE AIDE REFRESHER COURSE COMPLETION FORM

Complete this form and send to PHD, Inc. This form must be received within 30 days following completion of the program. Send to: Professional Health Care Development,
PO Box 399, Ona, WV 25545. Phone Number (304) 733-6145. Fax Number (304) 733-6146. This form should be typed or printed legibly.

The following individuals have completed a Nurse Aide Refresher Course at:

Name and Address of Facility or School

| | Name of Graduate: | | | Date of Birth | Street Address | City, State, Zip | Phone Number | County | Social Security # |
|----|-------------------|-------|--------|---------------|----------------|------------------|--------------|--------|-------------------|
| | Last | First | Middle | | | | | | |
| 1 | | | | | | | | | |
| 2 | | | | | | | | | |
| 3 | | | | | | | | | |
| 4 | | | | | | | | | |
| 5 | | | | | | | | | |
| 6 | | | | | | | | | |
| 7 | | | | | | | | | |
| 8 | | | | | | | | | |
| 9 | | | | | | | | | |
| 10 | | | | | | | | | |
| 11 | | | | | | | | | |
| 12 | | | | | | | | | |

Program Start Date: _____

Program Completion Date: _____

Signature of Primary Instructor _____

The Primary Instructor certifies the above information to be true and correct to the best of their knowledge.