NORTH DAKOTA BOARD OF CLINICAL LABORATORY PRACTICE
CONTINUING EDUCATION VERIFICATION RECORD

***Signed certificates of completion for each program or copy of your institutional record for internal programs must accompany this form or it will be returned and your renewal of license will not be processed!**

Name _____ License Number _____

Program Title	Date	Provider Name & Address	Internal(I) or External(E)	Contact Hours

I affirm I have attended the above continuing education programs and that this is an accurate record of my continuing education activities.

Licensee's Signature _____ Date _____

Supervisor's Signature _____ Date _____

***If you do not have a certificate of completion or institutional record for any of the internal programs listed, you must have your supervisor sign above attesting that you completed the internal program(s).**