

Medication Assistance Supervisor Recertification Certificate of Completion

This is to certify that

NAME OF RECIPIENT

*has successfully completed five (5) hours **Medication Assistance Supervisor Update** training and has met the requirements as established by the Alabama Department of Mental Health for continued certification as a **Medication Assistant Supervisor – MAS RN/LPN** - for delegating assistance responsibility to non-licensed healthcare workers.*

Program Date _____ *Expiration Date* _____

Certified By: _____ *MATT RN*