|  |
| --- |
| **Insert your Logo** |

**Training Organization Approved by the Texas Department of State Health Services**

**[Type Institution Name](Type institute Cert #)**

**Awards this:**

**Certificate of Completion**

**To: [Type participant Name]**

**Title: [Type workshop Name]**

**Date: [Type Date of Training/Course] Location: [Type city/state/distance**

**learning]**

**4 DSHS-Certified Continuing Education Hours for CHWs**

**(Competency Areas: [Hours] – [Competency])**

**DSHS-Certified CHW Instructor # [Type Instructor Cert. #]**

**[Type First and Last Name of CHW instructor here. Insert Your Hand-Written Digital Signature]**

**hhhhhhhhhhhhhhh**