# ""Certificate of Completion

[Institution Name] [Institute Cert #]

Training Organization Approved by the Texas Department of State Health Services

awards this certificate to

**[Name Goes Here]**

for participation in the

**[Workshop Name]  
[Date & Location]**

[Total Hours] **DSHS-Certified Continuing Education Hours for CHWs and CHW Instructors**

**Competency Area(s):** [Hours] – [Competency]

**DSHS-Certified CHW Instructor:** [Handwritten or digital signature here]

[First and Last Name, Instructor #]

[Your logo here]