

MM/DD/YYYY

Bariatric Seminar at Madigan Army Medical Center

As of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has Successfully Completed

This Award Certifies

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bariatric Program Provider or Nurse Signature Date

Patient Name

CERTIFICATE of COMPLETION