WESTERN DUBUQUE COMMUNITY SCHOOLS

CERTFICATE OF COMPLETION
BLOODBORNE PATHOGENS
2019-2020

THIS CERTIFICATE IS AWARDED TO

NAME: _____ DATE: _____
(Please Print)

MY SIGNATURE ON THE LINE BELOW ACKNOWLEDGES I HAVE VIEWED THE ONLINE BLOODBORNE PATHOGENS TRAINING PROVIDED TO ME ON THE DISTRICT'S WEBSITE IN ENTIRETY. MY SIGNATURE ALSO ACKNOWLEDGES THAT I UNDERSTAND THE CONTENT CONTAINED IN THE PRESENTATION AND UNDERSTAND THAT IF I HAVE QUESTIONS, IT IS MY RESPONSIBILITY TO CONTACT A SCHOOL NURSE BY CALLING ONE OF THE WESTERN DUBUQUE COMMUNITY SCHOOL DISTRICT SCHOOLS.

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SIGNATURE DATE