Certified Workers' Compensation Professional ©LASIE2003
Louisiana Association of Self Insured Employers

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Continuing Education Certificate of Attendance

(Optional - This form should only be used if a copy of the original certificate is not provided.)

This form is to certify that the person named below attended the following program on the date(s) indicated.

Name:

Title:

Company Name:

Mailing Address:

City/State/Zip:

Phone: ( ) Fax: ( )

E-mail:

Course Name:

Sponsoring Organization:

Course Date(s):

Course Length:

Print Name of Sponsor: _____

Sponsor Authorized Signature: _____

Date: _____

For Internal Use Only	
Date Received:	
Reviewed By:	
Date Approved:	