

**IOWA WESTERN COMMUNITY COLLEGE
CONTINUING EDUCATION CERTIFICATE**

IBN Provider 6

| | | | | |
|--|--------------|---|------------|---|
| Soc. Sec. Number | Name: Last | First | Initial | Birthdate Month/Day/Year |
| Address: Street | | City | State | Zip |
| | | | Home Phone | Work Phone |
| Course Number | Course Title | | Class Date | Times |
| e-mail address | | Course Location | | Gender: Male <input type="checkbox"/> Female <input type="checkbox"/> |
| Student Signature: _____ | | Ethnicity: Are you Hispanic or Latino/a? Yes / No <input type="checkbox"/> No Answer <input type="checkbox"/> Race (Check all that apply): American Indian / Native Alaskan <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian / Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> | | |
| | | COMPLETE ONLY IF APPLICABLE | | |
| Total Contact Hours Attended _____ | | Occupation | | |
| License or Certification Number: _____ | | Name of Employer | | |
| IWCC Representative Signature: _____ | | Address | | |
| | | Street | City | Zip |

Date: _____

White Copy: Student

Yellow Copy: Adult Education Office

NURSES: Retain certificate four years

EMS: Retain for six years

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