

# Certificate of Completion

*[Name of Participant]*

Has successfully completed the 6-week workshop for

**The Chronic Disease Self-Management Program  
Take Control of Your Health**

*(WORKSHOP DATES)*  
*(WORKSHOP LOCATION)*

\_\_\_\_\_  
Date

*(Agency Name  
and Logo)*

\_\_\_\_\_  
Workshop Facilitator

\_\_\_\_\_  
Workshop Facilitator

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Workshop Facilitator