FORM E

CERTIFICATION OF COMPLETION
OF NATIONALLY RECOGNIZED TRAINING PROGRAM
For Auricular Detoxification Technician Licensure

PART 1 – To be completed by the applicant.

Name: _____

Date of Birth: _____

SSN: _____

PART 2 – To be completed by the Program Director.

Name of the Program: _____

Sponsored by: _____

Program ID: _____

Address: _____

City/ State: _____ Zip Code: _____

Affiliated Institution: _____

This is to certify that the applicant named in Part 1 of this form has successfully completed the training program for Auricular Detoxification Technician:

from: _____/_____/_____ to _____/_____/_____

Program Director's Name _____

Program Director's Signature _____

Date _____

This form must contain the Institutional Seal.
If no seal is available, you are required to have this form notarized.

Notary's Name _____

Notary Signature _____

Please mail your completed form to:

Georgia Composite Medical Board
ATTN: Auricular Detoxification
2 Peachtree Street, NW – 36th Floor
Atlanta, GA 30303