South Dakota State University
College of Nursing

Verification of CPR Certification

This form needs to be completed by the CPR instructor verifying that our nursing student has completed all the necessary requirements to fulfill his/her completion of a Healthcare Provider CPR Training in Adult, Infant, and Child CPR.

Student First Name: _____ Student Last Name: _____

CPR Course Start Date (Month, Date, Year): _____ CPR Course End Date (Month, Date, Year): _____

CPR Association: _____ American Heart or _____ American Red Cross

CPR Training Site Location (Name of Facility, City, State): _____

CPR Instructor's First Name: _____ CPR Instructor's Last Name: _____

CPR Expiration Date (Month, Date, Year): _____

I verify that this information is accurate and truthful and that it may be confirmed. This course was taught in accordance with AHA or ARC guidelines.
Signature of CPR Instructor: _____ Date: _____

5/2018