## **Student Roster**

Provider: \_\_\_\_\_

## CPE Course Identification No.

Course Title:								
	1:							
(Facility Name) Course Date(s) & Time(s):				(City)		(State)		
		EndT	lime of					
			Sime:					
Date:  En   Date:  Start Time: En								
Date:	Start Time:	End I	1me:					
Signature of Provider/ Instructor(s):								
Please Print						For Provider Use Only		
LEGAL Name & Title		Work Phone Number	Employer's Nam	16	Driver's License No. & State of Issue	Hours	Certificate Rec'd (Initial)	

Within 5 days of course completion, send to: SCDCA- Credit Counseling CPE, P.O. Box 5757, Columbia, SC 29250-5757