



Office of Statewide Health
Planning & Development

Patient Data Section

www.oshpd.ca.gov/HID/MIRCal

CERTIFICATE *of* COMPLETION

Name: _____

Credential/License Number: _____

Course Title: **Medical Information Reporting for California - Computer Based Training**

Date of Completion: _____

Location: **Online Course**

Provider Name: **Office of Statewide Health Planning & Development,
Healthcare Information Division, Patient Data Section**

