Smoking Cessation Certificate

This certifies the enrollment of:

Client Name: _____

Provider Agency: _____

Provider Address: _____

Provider Phone: _____

This patient has completed the first smoking cessation counseling session and established the following quit date:

_____
Quit Date

_____
Agency title

- ❑ Provides health services to Medi-Cal clients
- ❑ Refers to Medi-Cal Providers

_____ _____ _____
Smoking Cessation Counselor Name | Signature | Date