Level 1 Medication Aide
Pre-Class Registration Form

Facility: ________________________________

Instructor: ________________________________

Location of Classes: ________________________________

Address: _______________________________________

_____________________________________________________

Telephone: _______________________________________

Scheduled Class Dates:

___________, 20___ - ____________ to ________________

___________, 20___ - ____________ to ________________

___________, 20___ - ____________ to ________________

___________, 20___ - ____________ to ________________

Final Examination:

___________, 20___ - ____________ to ________________

Mail this form and the Class Roster Form for prior approval of schedule to:

Missouri Health Care Association
Attn: Tina Struemph
236 Metro Drive
Jefferson City, MO 65109

Or Fax the forms to:
573-893-5248, Attn: Tina Stuemph

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FOR MHCA OFFICE USE ONLY:

TEST BOOKLETS: #_____ TYPE:_____

DATE SENT: ____________ DATE RECEIVED: ____________