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

FOR MHCA OFFICE USE ONLY:

TEST BOOKLETS: #_____ TYPE:_____

DATE SENT: _____ DATE RECEIVED: _____