Missouri Health Care Association

# CERTIFIED MEDICATION TECHNICIAN – REGISTRATION FORM

*Please Type or Print Legibly:*

| Name: | Date of Birth: | Social Security #: | Training Begin Date: | Registration # **(MHCA Use Only)** |
|---|---|---|---|---|
| (Example) *Jane Doe* | *08/15/89* | *000-00-0000* | *12/04/10* | *(leave blank)* |
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |
| 11. | | | | |
| 12. | | | | |
| 13. | | | | |
| 14. | | | | |
| 15. | | | | |

*Submitted to the Missouri Health Care Association office on this*_____ *day of* _____, *20*_____.

*Facility where certificates are to be mailed:*_____

*To the Attention of:*_____

*Address:*_____ *City/State/Zip:*_____

Send Information to: ***Missouri Health Care Association***
***236 Metro Drive***
***Jefferson City, MO 65109***

***Payment Options****:*

☐ *Check Enclosed* ☐ *MasterCard* ☐ *Visa* ☐ *American Express- 3.5% service charge applies* ☐ *Bill Facility*

*Credit Card Number:*_____ *Exp. Date:*____/____ *3 Digit Verification Code:*_____

*Signature required for credit card holders:*_____

***For Office Use Only:***

*Amount Received:*_____ *Check #:*_____ *Number of Pins:*_____ *Date Mailed:*_____