



Missouri Health Care Association

DINING ASSISTANT – REGISTRATION FORM

Please Type or Print Legibly:

Name:	Date of Birth:	Social Security #:	Training Begin Date:	Registration # <b>(MHCA Use Only)</b>
<u>(Example) Jane Doe</u>	<u>08/15/89</u>	<u>000-00-0000</u>	<u>1/04/14</u>	<u>(leave blank)</u>
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: \_\_\_\_\_

<b>For Office Use Only:</b>			
Amount Received: _____	Check #: _____	Number of Pins: _____	Date Mailed: _____