Missouri Assisted Living Association
2407 B Hyde Park Rd.
Jefferson City, MO 65109
Phone: 573/635-8750 Fax: 573/634-7344
info@malarcrf.org

LEVEL 1 MEDICATION AIDE
REQUEST FOR EXAMINATION

All information must be TYPED or PRINTED LEGIBLY

Instructor Name Telephone

Instructor Address City State Zip Code

Sponsoring Agency Telephone

Sponsoring Agency Address City State Zip Code

Training Site (if different) Telephone

Projected Class Dates: Hours:

_____, 20_____ _____ to _____

_____, 20_____ _____ to _____

_____, 20_____ _____ to _____

_____, 20_____ _____ to _____

Final Exam Date _____, 20_____ Total Hours _____
(Minimum of 16 hours)

Retest Date (if applicable) _____, 20_____

Total Tests Needed _____

*By signing this form, instructor confirms that course content and classroom space meets all requirements of Missouri 19 CSR 30-84.030

OFFICE USE ONLY

Instructor Approved:

Y N

Site Approved:

Y N

Date Test(s) Mailed:

_____

Test Mailed:

A B C

Date Returned:

_____

Request for Retesting:

Y N

Previous Test Form

A B C

Previous Exam Date

_____

_____
Instructor Signature*

_____
Instructor Nursing License Number

_____
E-Mail Address

Before requesting exams please call DHSS at 573/526-3871 to check on previous certifications.

Attach Pre-Class Roster and Return to:

Missouri Assisted Living Assoc.
2407 B Hyde Park Rd.
Jefferson City, MO 65109

Or Fax to 573/634-7344

*Testing material will be mailed to the sponsoring agency to the attention of the instructor unless otherwise noted.