

**Missouri Health Care Association  
Certification Process  
for  
Nurse Assistants**

**Information needed for Certification (75 hours + 100 OJT hours):**

1. Registration form with appropriate signatures (attached)
2. Copy of the Competency Record Sheet and Score Sheet (Appendix A-B) (attached)
3. Picture (1" x 1½")
4. If challenging - copy of the approval letter from the Department of Health and Senior Services

**Missouri Health Care Association Certification Program Includes:**

1. Certificate printed on safety paper clearly stating the ir completion of all requirements.
2. Laminated I.D. Card with picture
3. Name placed on MHCA permanent record.
4. Listing sent to Department of Health & Senior Services for the State Nurse Assistant Registry on a weekly basis for their records.
5. Nurse Assistant Pin (optional).

**Fees:**

**MHCA Member Facility**

Certificate and I.D. Card	\$ 4.00
Nurse Assistant Pin (optional)	<u>\$ 4.50</u>
	\$ 8.50

**Non-Member Facility**

Enrollment Fee per Registrant	\$10.00
Certificate and I.D. Card	\$ 4.00
Nurse Assistant Pin (Optional)	<u>\$ 4.50</u>
	\$18.50

**Information Needed for Duplicates/Name Changes**

**Certificate:**

1. Full name (at time of certification)
2. Certification number or name of nursing facility where training was completed
3. Return address
4. \$5.00 fee
5. If name change - copy of the marriage license or divorce decree

**Identification Card:**

1. Full name (at time of certification)
2. Certification number or name of nursing facility where training was completed
3. Return address
4. Picture (1" x 1½")
5. \$5.00 fee
6. If name change - copy of the marriage license or divorce decree

**MAIL ALL INFORMATION TO:  
MISSOURI HEALTH CARE ASSOCIATION  
236 METRO DRIVE  
JEFFERSON CITY, MO 65109**

**Missouri Health Care Association  
NURSE ASSISTANT – REGISTRATION FORM**

*Please Type or Print Legibly:*

<b>Name:</b> (EXAMPLE) Jane Doe	<b>Date of Birth</b> 08/15/89	<b>Social Security No.</b> 000-00-0000	<b>Training Begin Date:</b> 12/04/94	<b>Registration Number:</b> (Office Use Only)
------------------------------------	----------------------------------	---	---	--

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 Name: \_\_\_\_\_

Address: \_\_\_\_\_

R.N. Instructor: \_\_\_\_\_  
(Signature)

R.N. Examiner: \_\_\_\_\_  
(Signature)

Administrator: \_\_\_\_\_  
(Signature)

Send Information to: Missouri Health Care Assoc. 236 Metro Drive Jefferson City, MO 65109
--

Payment Options: " Check " Credit Card  
 " MasterCard " Visa \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Credit Card Number Expiration Date

Signature required for credit card orders \_\_\_\_\_

For office Use:  
 Amt. Received: \_\_\_\_\_ Check#: \_\_\_\_\_ Number of Pins: \_\_\_\_\_ Date Received: \_\_\_\_\_