

**Restorative Nurse Assistant
Record of Clinical Supervision**

Name of student _____
(Last) (First) (Middle) (Maiden)

Permanent Address _____

Date of Birth _____ Soc. Sec. No. _____

Training Site _____

Date started _____ Date completed _____

OJT started _____ OJT completed _____

Written exam score _____ %

R.N. Instructor _____
(Signature(s))

Supervisor Licensed Therapist(s) Signature(s):

<input type="checkbox"/> 1 _____	<input type="checkbox"/> 2 _____
<input type="checkbox"/> 3 _____	<input type="checkbox"/> 4 _____

Examiner: _____
(Signature)

Additional comments:

**MAIL TO: MISSOURI ASSOCIATION OF NURSING HOME ADMINISTRATORS
4100 Country Club., Jefferson City, MO 65109
Phone (573) 634-5345 * Fax (573) 634-8590**

