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## **Checklist to Transfer Level 1 Medication Aide** **from DMH to DHSS**

- Completed Level 1 Medication Aide Final Class Roster
- \$20 payment for certificate, ID card, and listing on Missouri State Registry. *Cash or money orders only (there is only one flat fee now)*
- Letter from DMH verifying 2-year update and that it is in good standing (we will no longer accept D.M.H certification)

You may reach us via phone or email with any questions:

Phone: (573)634-5345

Email: [crcmanha@mlnha.org](mailto:crcmanha@mlnha.org)

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Please send all items to:

MANHA

4100 Country Club Drive

Jefferson City, MO 65109

Missouri Association of Nursing Home Administrators

4100 Country Club Drive \* Jefferson City, MO 65109 \* 573/634-5345 \* Fax:573-634-8590

LEVEL I MEDICATION AIDE - FINAL CLASS ROSTER

I, the undersigned, hereby certify that the students whose names are listed below have completed the course of instruction and have satisfactorily passed the examination to qualify for certification as a Level I Medication Aide.

NAME first, Middle (Maiden)	Office Use Only	Social Security Number	Date of Birth	Student Address	Mental Health Certification	
					Manual Used	Certification
					<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

~~NAME~~ Write your Return Address

SPONSORING AGENCY/TRAINING SITE

N/A

ADDRESS

DATE

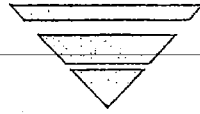
ADMIN/DIR OF SPONSORING AGENCY

CITY

STATE

ZIP

DIVISION OF  
DEVELOPMENTAL  
DISABILITIES



**Quality Enhancement RN Roster 10-2012**

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