# Missouri Association of Nursing Home Administrators

4100 Country Club Drive * Jefferson City, MO 65109 * 573/634-5345

## MEDICATION TECHNICIAN CERTIFICATION FORM

We, 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 Medication Technician.

| NAME<br>Last, first, Middle (Maiden) | Office Use<br>Only | Social Security Number | Date of Birth | Educational Verification |
|---|---|---|---|---|
| | | | | ☐ HS/GED ☐ CNA Cert. |
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| | | | | ☐ HS/GED ☐ CNA Cert. |

Submitted to the Missouri Association of Nursing Home Administrators' office this _____ day of _____ 2 _____

Name of Sponsoring School_____ Contact Person _____ Phone Number_____

Street, City, State, Zip_____