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):

☐ 1_____ ☐ 2_____

☐ 3_____ ☐ 4_____

Examiner:_____
(Signature)

Additional comments:

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MAIL TO:MISSOURI ASSOCIATION OF NURSING HOME ADMINISTRATORS
915 Southwest Blvd Ste J,
Jefferson City, MO 65109
Phone (573) 634-5345 * Fax (573) 634-8590