MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF AGING

APPLICATION FOR APPROVAL AS A NURSING ASSISTANT TRAINING AGENCY

	DATE SUBMITTED
TRAINING AGENCY NAME	TELEPHONE
ADDRESS	FAX NUMBER
ADMINISTRATOR/DIRECTOR	
INSTRUCTOR NAME	LICENSE NUMBER
ADDRESS	
EXAMINER NAME	LICENSE NUMBER
ADDRESS	

PLEASE CHECK THE FOLLOWING IF APPLICABLE:

☐ DA LICENSED FACILITY BASED

☐ DEPARTMENT OF HEALTH LICENSED/EXTENDED CARE WING OF HOSPITAL

☐ NON-FACILITY BASED
- ☐ VOCATIONAL-TECHNICAL SCHOOL (PUBLIC)
- ☐ VOCATIONAL-TECHNICAL SCHOOL (PRIVATE)
- ☐ JUNIOR COLLEGE
- ☐ COMMUNITY COLLEGE
- ☐ PRIVATE AGENCY
- ☐ HOSPITAL

NAME(S) OF FACIILTY(IES) WITH WHICH THERE IS/ARE A SIGNED AGREEMENT(S) FOR CLINCIAL ON-THE-JOB TRAINING. (ATTACH A COPY OF THE AGREEMENT FOR EACH CLINCIAL SITE.)

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NAME(S) AND ADDRESSES OF CLINCIAL SUPERVISOR(S) AND LICENSE NUMBERS

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STATE AGENCY

☐ APPROVE 2 YEARS ☐ DISAPPROVE ☐ WITHDRAW APPROVAL

REASON FOR DISAPPROVAL OR WITHDRAWAL OF APPROVAL

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SIGNATURE	DATE

MO 886-2757 (3-91)