MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
HEALTH EDUCATION UNIT

# RECIPROCITY REQUEST FORM

## CERTIFIED NURSE ASSISTANT

Individuals who are certified and active on another state's nurse aide registry shall not be required to challenge the final examination. Please provide all information requested below. The request shall include: the individual's legal name; social security number; current address; telephone number; email address; and proof of their current certified nursing assistant certificate

**PRINT ALL INFORMATION LEGIBLY**

| | | |
|---|---|---|
| SOCIAL SECURITY NUMBER: | DATE OF BIRTH: | |
| NAME: LAST | FIRST | MI |
| STREET: | | APT: |
| CITY: | STATE: | ZIP: |
| E-MAIL (PREFERRED): | PHONE #: | ALT PHONE #: |
| OUT OF STATE CERTIFICATE #: | YOU MAY SUBMIT YOUR INFORMATION TO: | |
| STATE / EXPIRES | EMAIL: cnaregistry@health.mo.gov<br>FAX: 573-526-7656 | |

**FOR INTERNAL USE ONLY**

☐ **APPROVED** ☐ **DENIED**

Reason for Denial: