

# Missouri Board of Nursing Home Administrators

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## MISSOURI PRECEPTOR APPLICATION

Name: \_\_\_\_\_

License Number: \_\_\_\_\_ Date Issued: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

### Employment Information:

Facility Name: \_\_\_\_\_ Title: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Preferred Method of Contact (Email/Phone): \_\_\_\_\_

Length of Employment: \_\_\_\_\_ Current Facility (Y/N): \_\_\_\_\_

\*If you have not been with this facility for at least one (1) year please provide an additional list of facilities that includes the above information to prove that you have been employed as an administrator for at least a total of one (1) year within the past three (3) years immediately preceding this application\*

Have you successfully completed the Board approved Preceptor Training Program? \_\_\_ Yes \_\_\_ No  
(If yes, please attach a copy of the certificate of completion)

### Agreement:

My signature below certifies that I have read and fully understand all of the requirements and rules as stated both on the Board's website and described in 19 CSR 73-2.031. My signature below also indicates that I completely understand my responsibility and the importance of the role of a Certified Preceptor.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_