ARKANSAS RESIDENTIAL ASSISTED LIVING ASSOCIATION
692 HONEYSUCKLE LANE
CABOT AR 72023
501-941-2075

ADMINISTRATOR CERTIFICATION PROGRAM
STUDENT REGISTRATION FORM

NAME: ____ DATE: ______________

FACILITY: ____

☐ LICENSED RCF/ALF ☐ IN PROGRESS ☐ NOT FACILITY ASSOCIATED

ADDRESS: ____

CITY: ____ ST: ____ ZIP: ___________

TELEPHONE NUMBER: _____________ FAX: _____________ EMAIL: ___________________

MEMBERSHIP STATUS: ☐ FACILITY ☐ ASSOCIATE ☐ NONMEMBER
☐ GOOD STANDING ☐ JOINING TODAY

SOCIAL SECURITY NUMBER ________--________--________ DATE OF BIRTH _____________

AGE: ____________ SEX: _____________ RACE: _______________

EDUCATIONAL LEVEL: ☐ HIGH SCHOOL/GED ☐ SOME COLLEGE ☐ COLLEGE GRAD
_____ HIGHEST DEGREE HELD ______ NURSING OR SOCIAL WORK

WORK HISTORY:

Please indicate any and all of the areas in which you have had experience by entering the approximate amount of time you have worked in that position.

______RCF/ALF _____ NURSING FACILITY ____ HOSPITAL ____ HOME HEALTH
______HOTEL _____ FOOD SERVICE/RESTAURANT _____OTHER HOSPITALITY
______COMMERCIAL HOUSEKEEPING ____MAINTENCE

I understand that to be eligible to work as an administrator of a Residential Care Facility or Assisted Living Facility in the state of Arkansas that I must meet certain requirements established by law and regulation and that successful completion of this program fulfils only the certification requirement. I also understand that the Arkansas Residential Assisted Living Association assumes no responsibility for any consequences attributed to or related to any use or interpretation of any information or views presented through this training program.

______________________________ ______________
Signature (office use)