

Certification# _____



Louisiana Certification Registry for Healthcare Ancillary Professionals, Inc.

P.O. Box 710; Marksville, LA 71351

(504) 390-8942

APPLICATION

Long Term Care Social Service Designee

Date _____

Last Name _____ First Name _____ Middle Initial _____

Mailing Address _____

Contact Phone Number _____

Email Address _____

Employer _____

Date Completed the LNHA SSD Program _____

Type of certification you are applying for:

Certified Long Term Care Social Service Designee

Have you ever had a professional license and/or certification revoked ____ Yes ____ No

If Yes, Please Explain: _____

Initial Application Fee:

Certified Long Term Care Social Service Designee= \$75.00

YOU MUST SUBMIT THE FOLLOWING WITH THIS FULLY COMPLETED, AND SIGNED

APPLICATION: Write your certification number in the top right corner of the application.

Make check or money order payable to: JAJ Health Care Education Consultants, L.L.C.

Mail to: JAJ Healthcare Education Consultants at P.O. Box 710; Marksville, LA 71351

Signature of Applicant _____