ARKANSAS STATE BOARD OF NURSING
1123 S. University Ave., Suite 800
Little Rock, AR 72204
501.686.2700
501.686.2714 Fax

Arkansas Department of Health
Division of Healthcare Related Boards & Commissions

MEDICATION ASSISTANT TRAINING CERTIFICATE OF COMPLETION FORM

GENERAL INFORMATION

In accordance with the Arkansas State Board of Nursing *Rules*, verification of successful completion of the medication assistant-certified (MA-C) program, including date of start and completion, shall be received in the Board office directly from the institution that provided the program.
The online submission of an examination application requires the program director or chairman (authorized official) of the MA-C program to verify a student's qualifications and graduate status **after** they have completed the program.

DIRECTIONS

This form must be completed by the MA-C program director (authorized individual) **after** the applicant has completed the program. Enter all information and **check the box approve or deny based on applicant status.** When form is complete, click on the yellow submit button at the bottom of the form. The form will attach to an email, with address already entered for the Board contact person.

Name of Applicant_____
First Middle Maiden Last

☐ I hereby **APPROVE** the application submitted by the above-named applicant and verify that the applicant started the MA-C program on_____ and successfully completed the MA-C program on_____.

_____
Name of Medication Assistant-Certified Program

_____
Street Address City State Zip Code

I **CERTIFY** that this individual:

- is currently listed in good standing on the state's nurse aide registry.
- has maintained registration on the state's certified nurse aide registry continuously for a minimum of one (1) year.
- has completed at least one (1) continuous year of full-time experience as a certified nurse aide in this state.
- is currently employed at a designated facility.
- has a high school diploma or the equivalent.
- has successfully completed a literacy and reading comprehension screening process approved by the Board.
- has successfully completed a medication assistant-certified training course approved by the Board.

☐ I hereby **DENY** the application submitted by the above-named applicant.

_____ _____
Signature of MA-C Director (Authorized Official) Title

_____
Date

Submit Completed Form