ARKANSAS STATE BOARD OF NURSING
DEPARTMENT OF ENFORCEMENT

CURRENT MEDICATION LIST

Please provide the following information: list all current medications that you are taking, including prescribed and over-the-counter, the dosage, the prescribing provider and contact information, and the reason for taking the medication.

Name of Medication	Dosage	Prescribing Provider & Contact Information	Reason for Taking the Medication

Name: _____ Date: _____ License #: _____