Arkansas Department of Health

Arkansas State Board of Nursing
1123 S. University Ave., #800 • Little Rock, Arkansas 72204 • (501) 686-2700 • Fax (501) 686-2714
Governor Asa Hutchinson
José R. Romero, MD, Secretary of Health
Sue A. Tedford, MNSc, APRN, Director

Instructions for Notification of Intent To Use Medication Assistants-Certified in Nursing Homes

Arkansas Code Annotated § 17-87-703 Designated Facilities, (b)(2) requires that "if a designated facility elects to use medication assistive personnel, the facility shall notify the board in a manner prescribed by the board."

The Arkansas State Board of Nursing, *Rules*, Chapter 8, Medication Assistant-Certified, Section VII – Nursing Homes Utilizing MA-C states, "Nursing homes utilizing MA-C persons shall notify the Board, on forms supplied by the Board. The notification shall be signed by the facility administrator and the director of nursing."

- Complete and sign the **NOTIFICATION OF INTENT TO USE MEDICATION ASSISTANTS –CERTIFIED (MA-Cs) IN NURSING HOMES** form on the next page.

- Return form to:
  Arkansas State Board of Nursing
  1123 S. University, Suite 800
  Little Rock, AR 72204

- If you have questions, call 501-686-2700

NOTIFICATION OF INTENT
TO USE MEDICATION ASSISTANTS –CERTIFIED (MA-Cs)
IN NURSING HOMES

NAME OF NURSING HOME_____

ADDRESS_____

CITY_____ **STATE**_____ **ZIP**_____

DIRECTOR OF NURSING_____

TELEPHONE NUMBER (____)_____ **EMAIL ADDRESS**_____

NUMBER OF MA-Cs PLANNED TO BE USED_____

SHIFTS THAT MA-Cs WILL BE UTILIZED (CHECK ALL THAT APPLY)
_____7 – 3 _____3 – 11 _____11 – 7

IF YOU HAVE A REHABILITATION UNIT, WILL YOU USE MA-Cs IN THIS AREA?_____

NUMBER OF MA-Cs THAT EACH REGISTERED OR LICENSED NURSE WILL BE SUPERVISING DURING THE SHIFT_____

NUMBER OF RESIDENTS THAT EACH MA-C WILL ADMINISTER MEDICATION TO_____

DOES YOUR INSTITUTION PLAN TO OFFER THE MA-Cs CONTINUING EDUCATION (CE) RELATED TO MEDICATION ADMINISTRATION THAT MEETS BOARD APPROVAL FOR CE REQUIREMENTS FOR CERTIFICATION RENEWAL?_____

DO YOU HAVE WRITTEN POLICIES THAT INCLUDE THE ROLE OF THE MA-C IN YOUR INSTITUTION?_____

HAS ANYONE IN YOUR INSTITUTION WORKED WITH MEDICATION ASSISTANTS IN OTHER STATES?_____
IF SO, WHAT STATES?_____

I AGREE TO COMPLY WITH THE ARKANSAS STATE BOARD OF NURSING RULES CHAPTER 8, RELATED TO MEDICATION ASSISTANTS. I ALSO AGREE TO NOTIFY THE ARKANSAS STATE BOARD OF NURSING IF A MEDICATION ASSISTANT-CERTIFIED VIOLATES CHAPTER 8, IS PLACED ON THE OFFICE OF LONG-TERM CARE ABUSE REGISTRY OR IS REMOVED FROM THE STATE'S CERTIFIED NURSE AIDE REGISTRY, OR HAS A POSITIVE CRIMINAL BACKGROUND CHECK.

_____**ADMINISTRATOR** _____**DON**
SIGNATURE **SIGNATURE**

_____ _____
PRINTED NAME AND DATE **PRINTED NAME AND DATE**

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