Arkansas Department of Health

Arkansas State Board of Nursing
1123 S. University Ave., #800 • Little Rock, AR 72204
(501) 686-2700 • Fax (501) 686-2714

MEDICATION ASSISTANT TRAINING (MA-C/CMA)
INITIAL CERTIFICATE OF COMPLETION FORM

GENERAL INFORMATION

In accordance with the Arkansas State Board of Nursing *Rules*, verification of successful completion of a medication assistant training program, including date of completion, shall be received in the Board office directly from the institution which provided the program. Graduates from the program may use the title Certified Medication Assistant (CMA) or Medication Assistant-Certified (MA-C). The on-line submission of an examination application requires the program director or chairman (authorized official) of the medication assistant training program to verify a student's qualifications and graduate status **after** they have completed the program.

DIRECTIONS

This form must be completed by the medication assistant program director (authorized individual) **after** the applicant has completed the program. **Check the box "approve" or "deny" based on applicant status.** Submit this completed form to Dr. Brandy Haley at brandy.haley@arkansas.gov for processing.

Name of Applicant

First Middle Maiden Last

Date of Birth

☐ I hereby APPROVE the application submitted by the above-named applicant and verify that the applicant started the training program on and successfully completed the program on

Name of medication assistant training program

☐ I **CERTIFY** that this individual:

- is currently listed in good standing on the state's nurse aide registry.
- 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 the medication assistant training course approved by the Board.

☐ I **VERIFY** that this individual has successfully completed additional inhalation and insulin curriculum and has proven competency.

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

Signature of Program Director (authorized official)

Title Date