ARKANSAS STATE BOARD OF NURSING
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Arkansas Department of Health
Division of Healthcare Related Boards & Commissions

MEDICATION ASSISTANT ADDITIONAL TRAINING OXYGEN INHALATION AND SUBCUTANIOUS INSULIN INJECTION COMPLETION FORM

GENERAL INFORMATION

Act 265 of 2025 expanded the Certified Medication Assistant (CMA)/Medication Assistant-Certified (MA-C) scope of work to allow the administration of oxygen inhalation and subcutaneous injections of insulin. Arkansas CMA/MA-C education programs began incorporating the expanded scope of work training in curriculum plans September 1, 2025, with the additional testing over oxygen and subcutaneous injection of insulin beginning October 1, 2025. Effective August 1, 2025, any CMA/MA-C will be required to obtain 15 additional training hours to lawfully be able to administer oxygen inhalations and subcutaneous injections of insulin. Individuals seeking endorsement of certification from another state will be required to complete the additional training if proof of training is not provided. All guidelines for CMA/MA-Cs are under the Arkansas State Board of Nursing Rules (Title 17. Chapter XXII. Part 127. Certified Medication Assistant /Medication Assistant-Certified) or under Arkansas Code Annotated § 17-87-701 through § 17-87-708.

DIRECTIONS

This form is only used for current CMA/MA-Cs and must be completed by the medication assistant program director (authorized individual) **after** the CMA/MA-C completes the additional training. The program director should verify the CMA/MA-C is on the AR registry. **Check the box "approve" or "deny".** Submit this completed form to Dr. Brandy Haley at brandy.haley@arkansas.gov for processing.

Name of CMA/MA-C _____
First Middle Maiden Last

CMA/MA-C certification number _____ expiration date _____

Social Security Number _____ Date of Birth _____

☐ I **VERIFY** that the above-named CMA/MA-C has successfully completed additional 15 hours of oxygen inhalation and insulin curriculum and has proven competence in both skills.

☐ I hereby **DENY** the request for oxygen inhalation and insulin competency of the above-named CMA/MA-C.

Signature of Program Director (authorized official) _____

Title _____ Date _____

Name of Program _____