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

Arkansas Department of Health

Division of Healthcare Related Boards & Commissions

# CERTIFIED ARKANSAS MEDICATION ASSISTANT VERIFICATION OF EMPLOYMENT FORM

**GENERAL INFORMATION**

In accordance with the Arkansas State Board of Nursing *Rules*, an applicant shall submit written evidence, verified by oath, that the applicant meets the Boards qualifications for certification as a medication assistant. This completed verification form will serve as official documentation of meeting the qualifications for eligibility of certification. Certified individuals may use either "Certified Medication Assistant (CMA)" or "Medication Assistant-Certified (MA-C)" title.

**INSTRUCTIONS FOR APPLICANT:**

- Complete the Applicant section of the Verification of Employment form.
- Forward the form and instructions to your most recent nursing home employer.
- The Verification of Employment form must be completed by the RN Director, Supervisor, or Human Resource officer.

**APPLICANT**

Name_____ Date of Birth _____
Address_____ City_____ State_____ Zip_____
Phone number_____ Email_____
CNA certification number_____ CMA/MA-C certification number_____
Name of most recent nursing home employed_____
*I hereby request and authorize my employer/former employer to release the information on this form to the Arkansas State Board of Nursing for certification purposes.*

_____ _____ _____
*Printed name of applicant* *Signature of applicant* *Date*

**INSTRUCTIONS FOR EMPLOYER:**

- Submit completed form to the Board in a sealed official envelope
  to: Arkansas State Board of Nursing
  Attn: Medication Assistant Endorsement
  1123 S. University Ave., Suite 800
  Little Rock, AR 72204

The above-named individual was employed as a CMA/MA-C at this facility from _____to_____.

Name of Facility_____
Address_____ City_____ State_____ Zip_____
Phone Number _____ Email _____
*I, the undersigned, declare and affirm that on this date, according to our records and to the best of my knowledge and belief, the information provided above for the purpose of certification is true and correct.*

_____ _____ _____
*Printed name of facility representative* *Signature of facility representative* *Date*