

Arkansas State Board of Nursing

University Tower Building
1123 South University Avenue, Suite 800
Little Rock, Arkansas 72204

PHONE 501.686.2700

FAX 501.686.2714

www.arsbn.org

INSTRUCTIONS FOR COMPLETION OF MEDICATION ASSISTANT-CERTIFIED ENDORSEMENT APPLICATION

I. QUALIFICATIONS

In order to be certified as a Medication Assistant-Certified (MA-C) in Arkansas, an applicant shall submit to the Arkansas State Board of Nursing written evidence that the applicant:

- a. Is currently listed in good standing in the state's certified nurse aide registry;
- b. Has maintained registration on the state's certified nurse aide registry continuously for a minimum of one (1) year;
- c. Has completed at least one (1) continuous year of full-time experience in a nursing home as a certified nurse aide;
SUBMIT A NOTARIZED STATEMENT FROM YOUR MOST RECENT NURSING HOME EMPLOYER VALIDATING a, b, and c above.
- d. Has a high school diploma or the equivalent;
- e. Has successfully completed a medication assistant-certified training course substantially similar to Arkansas approved programs (a minimum of 100 hours of classroom and clinical combined), and
- f. Has successfully passed a substantially similar medication assistant certification examination.

II. ENDORSEMENT APPLICATION FORM

- a. Sign affidavit in the presence of a notary public.
- b. Attach application fee: **Endorsement - \$65.00**
Credit cards are accepted - see application form for details.
PERSONAL CHECKS ARE NOT ACCEPTED. FEES ARE NOT REFUNDED.
- c. Return completed application form and fee to this office.

III. OPEN BOOK TEST

You are required to complete an open book test and score 90 percent or higher on the content of Chapter 8 - Medication Assistant - Certified of the Arkansas State Board of Nursing *Rules*. You may view and/or print Chapter 8 from our Web site through the "Rules" option. Contact our office and request the open book test be mailed to you. Return completed test along with Endorsement application and fee back to ASBN. If you score less than 90 percent, you will receive an alternate form of the test to complete. Failure to score 90 percent or higher on this second test will result in denial of endorsement into Arkansas as a medication assistant.

IV. VERIFICATION FORM

Mail the document entitled VERIFICATION FORM to the certifying agency in the state where you were originally certified. Please supply your full name, current address and original certificate number so that your records can be readily located. The certifying agency will complete the form and return it directly to this office. Some states charge a fee for this service.

V. CRIMINAL BACKGROUND CHECK

You must submit a State and Federal Criminal Background Check in Arkansas. For instructions and applicable forms visit our Web site at www.arsbn.org, click on forms and then select Criminal Background Checks, print forms and instructions. Follow instructions for submission of the forms. If forms are not appropriately completed, they will be returned to you causing delay in the processing of your application.

PLEASE NOTE: The Arkansas State Board of Nursing renews certifications on a staggered biennial birth date system. Your first certificate may be valid from 91 days to two years depending upon your birth date. Continuing education contact hours are required for certification renewal. For more information go to the Board's Web site - www.arsbn.org.

ARKANSAS STATE BOARD OF NURSING

UNIVERSITY TOWER BUILDING
1123 SOUTH UNIVERSITY, SUITE 800
LITTLE ROCK, ARKANSAS 72204

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MEDICATION ASSISTANT - CERTIFIED ENDORSEMENT APPLICATION

CONTACT THE ASBN OFFICE IF YOU EVER BEEN LICENSED AS A MEDICATION ASSISTANT IN ARKANSAS.
DO NOT COMPLETE THIS FORM.

I hereby make applicaton for Arkansas certification as a MA-C. The following evidence is submitted as proof of my eligibility to become a candidate for certification by interstate endorsement.

Full Name _____
(MISS, MS., MRS., OR MR) FIRST MIDDLE MAIDEN LAST

Address _____
STREET CITY STATE ZIP

Mailing address _____ E-mail _____
STREET/P.O.BOX CITY STATE ZIP

Date of Birth _____ Place of Birth _____
MONTH DAY YEAR CITY STATE

Social Security Number _____ Telephone number () _____

Name & Phone Number of Nearest Relative _____

ETHNIC INFORMATION (check one): African American Asian Indian Asian Other Hispanic
 Native American Pacific Islander White, not of Hispanic origin Other

GENERAL EDUCATION

High School _____ City/State _____ Graduation Year _____

If High School Equivalency: Name of Test _____ Test Score _____

MA-C EDUCATION

School _____ City/State _____

Entered: Month _____ Year _____ Graduated: Month _____ Year _____

CERTIFICATION

State of Original Licensure _____ Year _____ Certificate Number _____

List of all states in which you are currently practicing _____

Have you ever taken a certification exam? YES NO

Have you ever been convicted of a misdemeanor or felony, pled guilty or nolo contendere to any charge in any state or jurisdiction?
DWI's and similar offenses must be reported. (Traffic violations do not constitute a crime.) YES NO
(If yes, include a copy of the court docket, plea agreement, or conviction papers, and evidence that fines, restitution are paid.)

Have you ever had any license, certificate or registration disciplined (revoked, suspended, placed on probation or reprimanded) or voluntarily surrendered in any state or jurisdiction? YES NO
(If yes, include copy of Facts and Finding from Board and evidence of reinstatement of license)

Are you currently under investigation in any state or jurisdiction? YES NO

Do you currently engage in drug-related behavior, including the use of mood-altering drugs/substances and/or alcohol that would affect your functional abilities to perform while working as a MA-C? YES NO

In the last two years, have you been the subject of a chemical or alcohol dependency intervention or participated in chemical or alcohol dependency treatment/rehabilitation? YES NO
(If yes, submit all relevant documents, such as rehab program completion, support group meetings, drug screens, etc.)

(OVER)

FOR OFFICE USE ONLY
AR CERT. NO. _____
DATE _____

List work experience including most recent employment administering medications (include dates) _____

Indicate where you expect to be employed in Arkansas and the beginning date of employment there.

IMPORTANT: Incomplete applications, including transcripts and failed examination files will be deleted and discarded when there has been no action in the file (i.e. correspondence from applicant, retake of exam, etc.) for seven (7) years.

Endorsement Certification Fee \$65.00

METHOD OF PAYMENT

- In-state personal check
- Money order/cashiers check
- Credit card

**OUT-OF-STATE PERSONAL CHECKS
ARE NOT ACCEPTED
FEE IS NONREFUNDABLE**

CREDIT CARD INFORMATION

Complete below if paying by credit card. There is a nominal processing fee (listed below) assessed with paying your fees by credit card. The Arkansas State Board of Nursing does not receive any portion of the processing fee.

Type of card Visa MasterCard Discover

Cardholder's Name _____

Cardholder's billing address _____

_____ City _____ State _____ Zip _____

Credit Card # _____

Expiration date mm / yyyy Amount Paid _____

Signature _____

*Processing fee - Endorsement Certification - \$2.95

AFFIDAVIT

State of _____

County of _____

I, _____, being duly sworn, state that I am the person who is referred to in the foregoing application for certification in the State of Arkansas; that the statements herein contained are true in every respect; that I have complied with all requirements of the law; and that I have read and understand this affidavit. **I understand that if the processing of this application is not completed, the application becomes null and void one year from date received.** I also understand that falsification of this form is grounds for discipline against my certification.

APPLICANT'S SIGNATURE

Sworn to before me this _____ day of _____, 20_____

My Commission Expires _____

NOTARY PUBLIC

AFFIX
NOTARY SEAL
HERE