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

INSTRUCTIONS FOR NOTIFICATION OF INTENT TO USE MEDICATION ASSISTANTS-CERTIFIED IN DESIGNATED FACILITIES

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 – Designated Facilities Utilizing MA-C states, "Designated facilities 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 DESIGNATED FACILITIES** form on the next page.
- Return completed form to: Arkansas State Board of Nursing, 1123 S. University, Suite 800, Little Rock, AR 72204 or email to tammy.vaughn@arkansas.gov.
- If you have questions, call Tammy Vaughn at 501-686-2786.
- Please note that all Medication Assistant-Certified (MA-Cs) are required to obtain eight (8) hours of continuing education (CE) every two (2) Years to renew their certification. This is no longer offered in-person by the Arkansas State Board of Nursing. Courses can be accessed and completed at https://cebroker.com/.

NOTIFICATION OF INTENT TO USE
MEDICATION ASSISTANT-CERTIFIED (MA-Cs) IN DESIGNATED FACILITY

Designated Facility – any Board approved facility to include a nursing home or a facility operated as a local correction facility as defined by A.C.A. §12-41-107

Name of Designated Facility____
**If the designated facility is a chain, each facility using MA-Cs will need to submit a separate form.*

Address____

City______________________________________State___________________________Zip_____________

Telephone number____

Director of Nursing____

Email____

Number of MA-Cs planned to be used_____________________

Shifts that MA-Cs will be utilized *(check all that apply)* ____morning ____afternoon ____evening

If you have a rehabilitation unit, will you use MA-Cs in this area? ________________

Number of MA-Cs that each RN or LPN will be supervising during the shift__________________

Number of residents that each MA-C will administer medication to_____________

Do you have written policies that include the role of the MA-Cs in your institution? _____________

Has anyone in you institution worked with MA-Cs 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 Signature_______________________________________ Date_____________________________

Director of Nursing Signature___________________________________ Date_____________________________

Please return by email to tammy.vaughn@arkansas.gov or mail to: Arkansas State Board of Nursing
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Little Rock, AR 72204