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

MEDICATION ASSISTANT–CERTIFIED (MA-C)
VERIFICATION OF ORIGINAL CERTIFICATION FORM

GENERAL INFORMATION

In accordance with the Arkansas State Board of Nursing *Rules*, the Board may issue certification as a Medication Assistant-Certified (MA-C) by endorsement to an applicant who has been licensed or certified as a MA-C under the laws and rules of another state or territory. Endorsement verifications are accepted from the state of original certification only.

SEND THIS FORM TO THE GOVERNING BODY IN THE STATE OR JURISDICTION WHERE YOU WERE ORIGINALLY CERTIFICATED AS A MEDICATION ASSISTANT-CERTIFIED OR EQUIVALENT.

Applicant Name____ Original Certificate Number___________________
Address_____________________________________ City ___________________________ State___________ Zip______

The above-named person has applied for certification as a Medication Assistant-Certified (MA-C) by endorsement.
Please complete this form and return to:

Arkansas State Board of Nursing
Attn: MA-C Endorsement
1123 S. University Ave, Suite 800
Little Rock, AR 72204

I hereby verify that____ has successfully completed a training program at ____school for Medication Assistant training, which was state approved at the time of his/her program completion.

Date of Initial Certification_______________ Date of Expiration_______________
Type of Exam____

Has the above applicant's certificate ever been encumbered? YES____ (If yes, explain below or attach) NO____
____
____

Is applicant currently under investigation? YES____ NO____

Name of Agency____
Official Officer and Title____
Contact Information____

State of ____
Dated this ____________________ day of_______________, 20_______ SEAL