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