Instructions for Notification of Intent
To Use Medication Assistants-Certified in Nursing Homes

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 – Nursing Homes Utilizing MA-C states, “Nursing homes 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 NURSING HOMES form on the next page.

- Return form to:
  Arkansas State Board of Nursing
  1123 S. University, Suite 800
  Little Rock, AR 72204

- If you have questions, call 501-686-2700
NOTIFICATION OF INTENT
TO USE MEDICATION ASSISTANTS –CERTIFIED (MA-Cs)
IN NURSING HOMES

NAME OF NURSING HOME____________________________________________________________

ADDRESS___________________________________________________________________________

CITY_____________________________________ STATE_________________ ZIP________________

DIRECTOR OF NURSING_______________________________________________________________

TELEPHONE NUMBER (        )__________________    EMAIL ADDRESS__________________________

NUMBER OF MA-Cs PLANNED TO BE USED________________________

SHIFTS THAT MA-Cs WILL BE UTILIZED (CHECK ALL THAT APPLY)

__________7 – 3          __________3 – 11          __________11 – 7

IF YOU HAVE A REHABILITATION UNIT, WILL YOU USE MA-Cs IN THIS AREA?_______________

NUMBER OF MA-Cs THAT EACH REGISTERED OR LICENSED NURSE WILL BE SUPERVISING DURING THE
SHIFT________________

NUMBER OF RESIDENTS THAT EACH MA-C WILL ADMINISTER MEDICATION TO____________

DOES YOUR INSTITUTION PLAN TO OFFER THE MA-Cs CONTINUING EDUCATION (CE) RELATED TO MEDICATION
ADMINISTRATION THAT MEETS BOARD APPROVAL FOR CE REQUIREMENTS FOR CERTIFICATION
RENEWAL?________________

DO YOU HAVE WRITTEN POLICIES THAT INCLUDE THE ROLE OF THE MA-C IN YOUR INSTITUTION?_______

HAS ANYONE IN YOUR INSTITUTION WORKED WITH MEDICATION ASSISTANTS 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                 ______________________________DON
SIGNATURE                                                                                                                                  SIGNATURE

______________________________                                                 __________________________________
PRINTED NAME AND DATE                                                                                            PRINTED NAME AND DATE

Return form to:   Arkansas State Board of Nursing, 1123 So. University Ave., #800, Little Rock, AR  72204