D&S Diversified Technologies LLP
Headmaster LLP

HEADMASTER LLP
P.O. Box 6609, Helena, MT 59604-6609
800-393-8664 – Fax: 406-442-3357
www.hdmaster.com

Innovative, quality technology solutions throughout the United States since 1985.

ARKANSAS MEDICATION ASSISTANT CERTIFICATION EXAMINATION APPLICATION (Forms 1101RM & 1402RM)

INSTRUCTIONS: (Also see www.hdmaster.com)

DO NOT mail this HEADMASTER Examination Application to the Arkansas State Board of Nursing (ASBN)

1. **Complete** front and back sides of this HEADMASTER Application.
2. **Send** this completed application **with payment** to HEADMASTER, P.O. Box 6609 Helena, MT 59602
3. You **must include** proof of completion of an Arkansas State Board of Nursing (ASBN) minimum 100 hour approved Medication Assistant training program **OR** an official approval to test letter from the ASBN. (**Approval to test letter is ONLY used for equivalency candidates)**

NOTE: Facilities MAKE ALL CHECKS PAYABLE TO HEADMASTER.
Candidate Personal checks are NOT accepted. (See form 1402 RM)

Before submitting this testing application, please check off the following: (Incomplete applications will be returned to applicant for completion. If you are applying or will apply on line at www.hdmaster.com do not fill out or mail this paper application.)

- ☐ This application is filled out **completely** (front and back [page 2]) and **signed** where required.
- ☐ **Exam payment** and ASBN certification fees are included with the testing application.
- ☐ **I have attached proof (instructor signature)** of my Medication Assistant training **or official ASBN** approval to test letter.
- ☐ I have answered all the ASBN required questions and background information questions on page 3 and mailed any required supporting documentation to the ASBN.

Candidate Information: (form 1101 RM) Print clearly (Use Ink) **or Type** **(high volume users on-line registration is available at www.hdmaster.com)**

Social Security No._____-_____-_____ (Mandatory. Your SS number will only be shared with the Arkansas State Board of Nursing)

Applicant's Name_____
Last First MI Maiden name Former Name

Mailing Address (Street)_____Apartment# ____ or PO Box #_____

City_____ State_____ County_____ Zip_____

Home Telephone_____ Message/Work Phone_____

Birth Date (Month/Day/Year)_____/_____/_____ E-Mail Address: _____
(Mandatory) Providing your email address is your authorization for us to use it for confirmation and test results

I have successfully completed an ASBN approved 100 hour Medication Assistant Training Program.

(Equivalency candidates leave blank)

Program Code #_____ Program Name_____
(Obtain from your instructor)

Program Address:_____City:_____Zip:_____

Date Program Began:___/___/___ Date Training Completed___/____/___ Instructors Signature:_____

If training program is paying for your test, this section must be completed by Instructor or Training Supervisor. (Please print)

Training Program Name_____ Phone_____

Address_____ Contact Person_____

Signature of Instructor/Supervisor_____ Date_____

I hereby declare that all supplied information is true, complete, and accurate to the best of my knowledge. Providing false information is punishable under Arkansas Code Annotated § 17-87-707 and sanctions by the ASBN. I hereby authorize release of my test results to my training program. I will honor my test appointment and agree to forfeit all test fees as payment for services provided if I do not show up for my test appointment or fail to reschedule or cancel my test appointment in a timely manner as listed in the Arkansas medication assistant candidate handbook. I will be responsible for any cancellation or rescheduling fees incurred as described in the HEADMASTER / Arkansas Board of Nursing Medication Assistant candidate handbook. (Candidate handbook is available on line at www.hdmaster.com or by calling HEADMASTER – 800-393-8664.)

Candidate Signature_____
Candidate MUST sign to verify acceptance (unsigned applications will be returned) Date

D&S Diversified Technologies LLP
Headmaster LLP

HEADMASTER LLP
P.O. Box 6609, Helena, MT 59604-6609
800-393-8664 – Fax: 406-442-3357
www.hdmaster.com

Innovative, quality technology solutions throughout the United States since 1985.

Please call the Helena office if you don't get an e-mail or mail response within ten days.

TESTING OPTIONS: Only use Option 1 **or** Option 2, **never both**.
(Equivalency candidates check this box ☐ for the Next Available Test. Do not fill out Option 1 or 2.)

Testing Option 1: Regional Test Sites – Paper application must be received at least ten days before first requested test date.

1st Choice Test Date: (From published 1700 RM Test Schedule)		**2nd Choice Test Date: (From published 1700 RM Test Schedule)**	
_____	_____	_____	_____
4 Digit Test Site #	Test Site Name	4 Digit Test Site #	Test Site Name
_____	_____	_____	_____
Test Month	Test Date	Test Month	Test Date

Testing Option 2: In-Facility Test Sites

(Medication Assistant instructor must complete this section. The training program must be an ASBN/D&SDT certified test site to use this option.)
(High volume users may use Internet electronic application submission. Call 800-393-8664 for WEBETEST© application options and training.)

Name of Site_____ 4 Digit Test Site #_____

Contact Person_____ Phone_____

Contact Person E-Mail_____

Pre-scheduled Test Observer_____ ID#_____

Date of Testing_____ Start time for Testing: _____AM flight start _____PM flight start

Site Address_____ City_____ State_____ Zip Code_____

List up to twelve candidate(s) Social Security numbers for In-Facility Testing:

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

Exam Types and Fee Payment: (form 1402 RM)

# Requested	Tests / Service Requested	Cost per Test	Totals
	Written test or written retake (Required Fee)	$71.00 -- Initial & Retake -- Non-refundable	
	ASBN certification fee (Required Fee)	$35.00/candidate – Initial & Retake -- Non-refundable	
	Priority Fax Service (Optional Fee)	$5.00/candidate	
	Overnight Shipping (Optional Fee)	$25.00/candidate	
	Express Service Fee (Optional Fee)	$15.00/candidate	
	Reschedule	$35.00/candidate	
	*No Show	*No Refund	

Grand Total: _____

Check method of payment: _____Check (Facility Only) _____ Cashier's Check _____Money Order _____ Visa ____ Master Card

Card #:_____ Expiration Date:_____ Authorized Signature:_____

Print name as it appears on your credit card:_____ Zip Code_____

ADA ACCOMMODATION

I need special accommodation under the Americans with Disabilities Act. To qualify for special accommodations, you must provide written documentation of your disability along with your application. ADA form 1404 RM is available at www.hdmaster.com or call 800-393-8664.

D&S Diversified Technologies LLP
Headmaster LLP

HEADMASTER LLP
P.O. Box 6609, Helena, MT 59604-6609
800-393-8664 – Fax: 406-442-3357
www.hdmaster.com

Innovative, quality technology solutions throughout the United States since 1985.

OFFICIAL USE ONLY: Site_____ Packet#_____ Test Date_____ Scheduler_____

ARKANSAS STATE BOARD of NURSING
Additional Required Information

For office use only:
AR CERT #:____
Date:_____

Applicant's Name: _____

Place of Birth:_____

MANDATORY ETHNIC INFORMATION: (Check one) ☐ African American ☐ Asian Indian ☐ Asian Other ☐ Hispanic
☐ Other _____ ☐ Native American ☐ Pacific Islander ☐ White, not of Hispanic Origin

Arkansas CNA Certificate Number:_____ List other States in which certification is held:_____

Name certification is issued under if different than name given on page one:_____
(Must attach official documentation of name change, if names don't match):

BACKGROUND INFORMATION QUESTIONS: (check Yes or No and include ALL required documentation.)

- Are you listed on the Arkansas CNA registry in good standing?..... ☐ Yes ☐ No
- Have you ever been convicted of a misdemeanor or felony or pled guilty or nolo contendere to any charge in any state or jurisdiction? ……..☐ Yes ☐ No

  If Yes, you must include a copy of the court docket, plea agreement, or conviction papers, and evidence that all fines and/or restitution has been paid. Send certified copies to ASBN. **Note:** With the exception of DWI, traffic violations do not constitute a crime.
- Are you currently under investigation in any state or jurisdiction? …….. ☐ Yes ☐ No
- Have you ever had any license, certificate, or registration that was disciplined (revoked, suspended, placed on probation or reprimanded) or voluntarily surrendered in any state or …….☐ Yes ☐ No jurisdiction?

  If Yes, you must include all related documents and evidence of reinstatement of license, certificate, or registration. Send supporting documents to ASBN.
- Do you currently engage in drug-related behavior, including the use of mood-altering drugs or substances and/or alcohol that would affect your functional abilities to perform while working. ☐ Yes ☐ No as a Medication Assistant in Arkansas?
- 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 or rehabilitation? ……☐ Yes ☐ No

  If Yes, you must include all related documents, such as Rehab program completion, support group meetings, drug screens, etc. Send supporting documents to ASBN.

By signing below I affirm that the contents of this document are true and correct to the best of my knowledge and belief, and that I have met all educational requirements to be certified as a Medication Assistant in Arkansas. I understand that falsification of any information is grounds for disciplinary action against my certification(s) and possible legal sanctions to the full extent of the law.

Applicant Signature:_____ Date:_____/_____/_____