

**Doug Ducey**  
Governor



**Joey Ridenour**  
Executive Director

## Arizona State Board of Nursing

### MEDICATION ASSISTANT TRAINING PROGRAM INSTRUCTOR APPLICATION

#### PROGRAM INFORMATION

Name of MA Training Program		Program Code	
Name of Supervisor/Administrator/DON	Telephone #	Email Address	
Address	City	State	Zip

#### INSTRUCTOR INFORMATION

Full Name of Instructor (as it appears on license)	RN License #
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#### PLEASE PROVIDE EVIDENCE OF THE FOLLOWING:

Forty (40) hours of experience administering medications in a licensed long-term care facility.

FACILITY NAME/LOCATION	POSITION	CLINICAL AREA	FROM MONTH/YEAR	TO MONTH/YEAR

Experience teaching adults.

LOCATION	CLASS YOU TAUGHT	FROM MONTH/YEAR	TO MONTH/YEAR

#### VERIFICATION

I hereby certify that I have read this application and further certify that the information provided is true and correct. I also certify that I have read HB 2469 and understand the qualifications and responsibilities of the medication assistant training program instructor.

Applicant Signature	Date
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I hereby certify that I have reviewed official transcripts and work experience and have verified that the applicant meets the qualifications for program instructor as set forth by the Arizona Nurse Practice Act.

Supervisor Signature	Date
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#### OFFICIAL USE ONLY

<input type="checkbox"/> Unencumbered RN License	<input type="checkbox"/> Experience Medication Administration	<input type="checkbox"/> Experience Teaching Adults
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<input type="checkbox"/> Instructor Approved	<input type="checkbox"/> Instructor Denied	Reason for Denial
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Name of Reviewer	Date
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