



## Arizona State Board of Nursing Certified Medication Assistant (CMA) Request for Waiver

<b>APPLICANT INFORMATION</b>			
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Name		Social Security Number	
Address	City, State, Zip	Telephone #	Email Address

I hereby certify that the information provided is true and correct. I also certify that I have read Nurse Practice Act Statutes ARS § 32-1650, 32-1650.01, 32-1650.02 and 32-1650.05, and understand the qualifications and responsibilities of a certified medication assistant. (To see statutes, go to [www.azbn.gov/NursePracticeAct.aspx](http://www.azbn.gov/NursePracticeAct.aspx) and click on CMA statute link)

Signature of Applicant for Waiver	Date
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<b>WAIVER FOR NURSING STUDENTS AND INSTRUCTOR VERIFICATION</b>	<b>WAIVER FOR CERTIFIED MEDICATION ASSISTANTS AND EMPLOYER VERIFICATION</b>
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<p>Required:</p> <ul style="list-style-type: none"> <li>A nursing course as part of an approved RN/LPN program; which includes a block I or nursing fundamentals course with theory and clinical</li> <li>A 3 credit pharmacology course</li> <li>Instructor verification that student spent a minimum of 40 hours administering medications in a long term care facility.</li> </ul>	<p>Required:</p> <ul style="list-style-type: none"> <li>Verification from out of state registry sent directly to AZBN showing evidence of completion of 100 hours of training in a CMA program.</li> <li>Proof that you have practiced as a medication assistant in a long term care facility for at least 160 hours in the past two years OR completed a medication assistant program in the past year.</li> </ul>
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Name and Address of School	Name of Facility submitting verification
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Name of nursing fundamental course	Total clock/credit hours of course	Address of Facility
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Name of pharmacology course	Total clock/credit hours of course	Dates of employment as Certified Medication Assistant From: _____ To: _____
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Did student spend 40 hours in clinical administering medications? Yes _____ No _____	Did applicant work at least 160 hours as a CMA? Yes _____ No _____
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Signature of Instructor or Program Director attesting to the veracity of the above information	Signature of Supervisor attesting to the veracity of the above information
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Contact Phone	Contact Email	Contact Phone	Contact Email
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