ARKANSAS DEPARTMENT OF HEALTH
OFFICE OF ALCOHOL TESTING
201 S. MONROE ST.
LITTLE ROCK, AR 72205

Email: adh.lab.alcoholtesting@groups.arkansas.gov **Telephone (501) 661-2425**

APPLICATION FOR CERTIFICATION TO PERFORM BREATH TESTS

Class Date You Are Enrolling For:_____/_____/_____

APPLICATION FOR: _____OPERATOR _____SENIOR OPERATOR _____TRANSFER

TYPE OR PRINT FULL NAME OF APPLICANT - Do not use nicknames. **New Card Needed: ______________**

NAME ____________________________________ ______________________________ ______________________________
Last First Middle

TITLE ____ **D.O.B.**____________________________
mm / dd / yyyy

EMPLOYED BY ____ **Phone**_______________________

CERTIFICATION REQUESTED AT ____
Installation Name

Have you ever been certified for Breath Testing in Arkansas? _________Yes _________No

If yes, Where? ____ **Operator #** ________________________
Installation Name

Where were you employed? ____ **Date Left** ____/_____/____

____ ___________________________ _______________
Signature - Official at Agency of Employment Title Date

____ ___________________________ _______________
Signature - Official at Certified Installation Title Date

____ ___________________________ _______________
Signature of Applicant Title Date

Office of Alcohol Testing Use Only!

Training ________ Evaluation_______	Date ___________________	Cert. No. ________ --- _______________
Transfer _______	Grade ___________________	Cert. Date ___________________________
	Instructor ________________	Expir. Date ___________________________

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