



ARKANSAS DEPARTMENT OF HEALTH
COMMUNITY HEALTH WORKER CERTIFICATION
CHW SUPERVISOR AFFIDAVIT FORM

I, _____, confirm to being a certified community health worker
(name)
in the state of Arkansas, who has completed community health worker supervisor training,
and has served as a supervisor for _____, from _____
(name) (beginning date)
to _____ with regular communication at least two (2) times per week during the
(ending date)
first three (3) months of supervision and at least weekly thereafter.

By placing my signature below, I confirm that all information provided in this form is true and correct, and have included documentation of my completion of community health worker supervisor training.

Signature

Date (Month/Day/Year)

No form will be accepted or application processed without a notarized signature.

State of _____

County of _____

Subscribed and sworn before me, a Notary Public, in and for the county and state aforesaid, this the _____ day of _____, 20____.

Notary Seal

Notary Public Signature