



ARKANSAS DEPARTMENT OF HEALTH

COMMUNITY HEALTH WORKER CERTIFICATION APPLICATION PATHWAY A

Last Name		First		Middle		Social Security Number		
						Date		
Street			City			State		
						Zip		
Mailing Address, if different								
Home Phone ()		Business Phone ()			Other Phone (cell, pager, etc.) ()			
Email								
Date of Birth		Have you attended school, been certified, or licensed under a different name? ☐ Yes ☐ No If yes, what name(s)						
Did you graduate high school? ☐ Yes ☐ No If No, do you have a GED or High School Equivalency? ☐ Yes ☐ No?								
From Where?				Date Obtained:				
Highest Grade Completed		Date Completed		Name of High School		Address		
						State Zip		
College or Vocational Training Name and Address of School			Dates Attended		Total Credit/ Clock Hours		Date of Diploma or Certificate	
			From To					
			From To					
			From To					
Certification as a Community Health Worker by the Arkansas Community Health Worker Association (ARCHWA) ☐ Yes ☐ No								

Current Health-Related Other Licenses/Certification Name or Trade or Profession	State	Certification/License Number	Expiration Date

Have you ever had a certification/license revoked in any health-related field? ☐ Yes ☐ No

If yes, specify:

Have you ever been convicted of a crime? ☐ Yes ☐ No

If yes, a detailed statement, a summary of the charges, the final order, any probation or parole documentation, and any other relevant information must be attached and received before your application will be processed.

Please list any other states or territories where you have held a community health worker certification and indicate whether the certification is current:

(Verification of certification from the state where the certification is held may be requested)

Has your application for any professional certificate, license, registration, etc. been denied by any state licensing/certification board or federal authority?
☐ Yes ☐ No

If yes, specify

I certify that all information given on this application is true and accurate. That in consideration of the issuance to me of a certificate to practice in Arkansas, I swear that I shall observe, abide by and uphold the laws of the State of Arkansas governing my practice and that I shall abstain from unethical, deceptive and fraudulent methods of practice and from unprofessional and unethical conduct, and that I shall not associate professionally with nor become a partner or employee of any person who resorts to such practices. I hereby agree that the violation of this oath shall constitute cause sufficient for the revocation of said certificate and surrender of the rights and privileges accorded me there under.

Signature of Applicant

Date

**ARKANSAS DEPARTMENT OF HEALTH
COMMUNITY HEALTH WORKER CERTIFICATION APPLICATION
PATHWAY A**

PROCEDURES FOR APPLYING FOR COMMUNITY HEALTH WORKER CERTIFICATION

Type or print the application and check thoroughly before submitting. An incomplete application will delay processing. All items must be on file before your application will be considered. If any of your application documentation requires additional information the review process may take longer. Apply far enough in advance to allow for processing time.

All applicants must submit the following items:

- ☐ 1. Complete application form.
- ☐ 2. Copy of one of the following documents that demonstrates the applicant is 18 years of age or older:
 - ☐ A. Birth Certificate
 - ☐ B. U.S. Passport, current or expired
 - ☐ C. U.S. Driver's License or other state-issued identification document
 - ☐ D. Document issued by federal, state or provincial registrar of vital statistics
- ☐ 3. Notarized affidavit documentation of certification by the Arkansas Community Health Worker Association (ARCHWA) **and** a copy of the certificate of completion or a verification letter directly from the association.
ADH may request additional documentation to support applicants' qualification or certifications. It is the responsibility of the applicant to ensure relevant documentation is provided upon request.
- ☐ 4. Check or money order made payable to the Arkansas Department of Health for \$50.

NOTE:

- Applicant's name must be the same on all documents or the applicant must submit proof of name change with application.
- ADH has the option to request verification of completion of training programs, or of other certifications/licensures held.

Mail all forms, attachments, and payments to:

ARKANSAS DEPARTMENT OF HEALTH
ATTN: CHW CERTIFICATION
4815 W. MARKHAM ST.
SLOT 41
LITTLE ROCK, AR 72205



ARKANSAS DEPARTMENT OF HEALTH
COMMUNITY HEALTH WORKER CERTIFICATION
APPLICANT AFFIDAVIT FORM

By my signature below, I, _____, confirm that all information concerning my work history as a community health worker and/or completion of a community health worker training as presented on my application and as an attachment with this form is true and correct.

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