ARKANSAS DEPARTMENT OF HEALTH
COMMUNITY HEALTH WORKER
CERTIFICATION APPLICATION
PATHWAY C

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		

Worked as a Community Health Worker for one (1) year (2,000 hours) in the state of Arkansas:
☐ Yes ☐ No

Completed eighty (80) hours of supplemental training which supports core competencies and professional development:
☐ Yes ☐ No

Have a mentor who is a certified Community Health Worker in the state of Arkansas or is eligible to apply for certification:
☐ Yes ☐ No

Regularly accessed and communicated with mentor at least two (2) times per month during the first three (3) months of mentorship and monthly thereafter:
☐ Yes ☐ No

Have a supervisor who has completed community health worker supervisor training:
☐ Yes ☐ No

Regularly accessed and communicated with supervisor at least two (2) times per month during the first three (3) months of supervision and weekly for the remainder of the year.
☐ 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 C

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 regarding completed training and a copy of the completed training certificate or letter of verification from the training program.

☐ 4. Notarized affidavit form from a mentor who is a certified CHW in the state of Arkansas.

☐ 5. Notarized affidavit documentation of at least one (1) year (2,000 hours) of work history as a Community Health Worker in the state of Arkansas from a supervisor who has completed CHW supervisor training and documentation of supervisor's completion of CHW supervisor training.
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.

☐ 6. 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

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

ARKANSAS DEPARTMENT OF HEALTH

COMMUNITY HEALTH WORKER CERTIFICATION
MENTOR AFFIDAVIT FORM

I, _____, confirm to being a certified community health worker in
(name)
the state of Arkansas, and have served as a mentor for _____,
(name)
from _____ to _____ with regular communication at least two (2) times per
(beginning date) (ending date)
month during the first three (3) months of the mentorship and at least monthly thereafter.

By placing my signature below, I confirm that all information provided in 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