ARKANSAS DEPARTMENT OF HEALTH
COMMUNITY HEALTH WORKER
CERTIFICATION APPLICATION
PATHWAY D

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 four (4) years with two (2) years (4,000 hours) in the state of Arkansas:
☐ 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

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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 at least four (4) years of work history as a Community Health Worker, with two (2) years (4,000 hours) in the state of Arkansas from supervisor/director documenting work history (multiple letters may be necessary to cover requested timeframe).
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 SUPERVISOR/DIRECTOR AFFIDAVIT FORM

I, _____, confirm _____ has worked as a
(name) (CHW certification applicant)

Community health worker at _____ located in the state of
(name of business/employer)

_____, from _____ _____ to _____ _____.
(name of state) (month) (year) (month) (year)

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