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