ARKANSAS DEPARTMENT OF HEALTH
COMMUNITY HEALTH WORKER
RECIPROCAL CERTIFICATION APPLICATION

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)		

Do you currently hold a community health worker certification or license issued by another state, territory, or district of the United States? ☐ Yes ☐ No

If yes, is the certification or license suspended or probationary?

☐ Yes ☐ No

Please list current occupational certification or license to be a Community Health Worker

CHW Occupational Certification/Licensure	Issuing entity (state, territory, or U.S. district)	Status	In Good Standing?
		☐ Current ☐ Expired	☐ Yes ☐ No
		☐ Current ☐ Expired	☐ Yes ☐ No
		☐ Current ☐ Expired	☐ Yes ☐ No

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.
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 certification and surrender of the rights and privileges accorded me there under.

Signature of Applicant Date

ARKANSAS DEPARTMENT OF HEALTH
COMMUNITY-BASED DOULA RECIPROCAL CERTIFICATION APPLICATION

PROCEDURES FOR APPLYING FOR COMMUNITY-BASED DOULA 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 Applicant Affidavit with proof of equivalent certification/licensure. 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. Letters of good standing or other information from each state, territory, or district in which the applicant is currently or has ever been certified or licensed showing the applicant has not had a certification or license revoked and does not hold a certification or license on suspended or probationary status.

☐ 5. 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 contained in my application concerning my identity and my certification/licensure history as a community health worker from another state, territory, or district in the United States as presented on my application and as an attachment(s) 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