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