



## ARKANSAS DEPARTMENT OF HEALTH COMMUNITY-BASED DOULA AUTOMATIC 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
		If yes, what name(s)			
Are you a uniformed service member, veteran, or a spouse of a service member or veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, which describes your residency?					
<input type="checkbox"/> 1. Uniformed service member stationed in the State of Arkansas					
<input type="checkbox"/> 2. Uniformed service veteran who resides in or has established residency in the State of Arkansas					
<input type="checkbox"/> 3. Spouse of either 1 or 2 listed above					
Do you have a current occupational certification or license to be a Community-Based Doula? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Doula Occupational Certification/Licensure	Issuing entity (state, territory, or U.S. district)	Status	In Good Standing?		
		<input type="checkbox"/> Current <input type="checkbox"/> Expired	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Current <input type="checkbox"/> Expired	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Current <input type="checkbox"/> Expired	<input type="checkbox"/> Yes <input type="checkbox"/> No		

<p>Have you ever had a certification/license revoked in any health-related field? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, specify:</p>
<p>Have you ever been convicted of a crime? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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.</p>
<p>Has your application for any professional certificate, license, registration, etc. been denied by any state licensing/certification board or federal authority?  <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, specify</p>

I certify that all information given on this application is true and accurate. That in consideration of the issuance to me of a license 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 license and surrender of the rights and privileges accorded me there under.

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Signature of Applicant Date

**ARKANSAS DEPARTMENT OF HEALTH  
COMMUNITY-BASED DOULA AUTOMATIC CERTIFICATION APPLICATION**

**PROCEDURES FOR APPLYING FOR COMMUNITY-BASED DOULA CERTIFICATION**

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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. Notarized 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. Documentation of equivalent certification/licensure in the form of a notarized copy of occupational 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. 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  
WOMEN'S HEALTH SECTION, SLOT 16  
ATTN: DOULA CERTIFICATION  
4815 W. MARKHAM ST.  
LITTLE ROCK, AR 72205