

**ARKANSAS DEPARTMENT OF HEALTH  
 OFFICE OF ALCOHOL TESTING  
 201 S. MONROE ST.  
 LITTLE ROCK, AR 72205**

Email: adh.alcoholtesting@arkansas.gov    FAX (501) 661-2289    Telephone (501) 661-2560

**APPLICATION FOR CERTIFICATION TO PERFORM BREATH TESTS**

Class Date You Are Enrolling For: \_\_\_\_/\_\_\_\_/\_\_\_\_

<b>APPLICATION FOR:    <input type="checkbox"/> OPERATOR       <input type="checkbox"/> SENIOR OPERATOR       <input type="checkbox"/> TRANSFER</b>		
<b>TYPE OR PRINT FULL NAME OF APPLICANT - Do not use nicknames.</b>		<b>New Card Needed:</b> _____
<b>NAME</b> _____	_____	_____
Last	First	Middle
<b>TITLE</b> _____	<b>D.O.B.</b> _____	
	mm / dd / yyyy	
<b>EMPLOYED BY</b> _____	<b>Phone</b> _____	
<b>CERTIFICATION REQUESTED AT</b> _____	<b>Installation Name</b>	
<b>Have you ever been certified for <u>Breath Testing</u> in Arkansas?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>If yes, Where?</b> _____		<b>Operator #</b> _____
<b>Installation Name</b>		
<b>Where were you employed?</b> _____		<b>Date Left</b> ____/____/____
_____	_____	_____
<b>Signature - Official at Agency of Employment</b>	<b>Title</b>	<b>Date</b>
_____	_____	_____
<b>Signature - Official at Certified Installation</b>	<b>Title</b>	<b>Date</b>
_____	_____	_____
<b>Signature of Applicant</b>	<b>Title</b>	<b>Date</b>
_____	_____	_____
<b>Office of Alcohol Testing Use Only!</b>		
<b>Training</b> _____	<b>Evaluation</b> _____	<b>Date</b> _____
<b>Transfer</b> _____		<b>Cert. No.</b> _____ --- _____
		<b>Cert. Date</b> _____
	<b>Instructor</b> _____	<b>Expir. Date</b> _____

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