

**ARKANSAS DEPARTMENT OF HEALTH
OFFICE OF ALCOHOL TESTING
BOX 8509
LITTLE ROCK, ARKANSAS 72215-8509**

FAX (501) 661-2289

Telephone (501) 661-2287

APPLICATION FOR CERTIFICATION TO PERFORM BREATH TESTS

Class Date You Are Enrolling For: ____/____/____

APPLICATION FOR: ____ OPERATOR ____ SENIOR OPERATOR ____ TRANSFER

TYPE OR PRINT FULL NAME OF APPLICANT - Do not use nicknames.

NAME _____
Last
First
Middle

TITLE _____ WORK PHONE ____ (____) _____

EMPLOYED BY _____

CERTIFICATION REQUESTED AT _____
Installation Name

Have you ever been certified in Breath Testing in Arkansas? ____ Yes ____ No

If yes, Where? _____
Installation Name

Where were you employed? _____ Date Left _____

Signature - Official at Agency of Employment
Title
Date

Signature - Official at Certified Installation
Title
Date

Signature of Applicant
Title
Date

Office of Alcohol Testing Use Only!

Training _____	Evaluation _____	Date _____	Cert. No. _____
Transfer _____		Grade _____	Cert. Date _____
		Instructor _____	Expir. Date _____