

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

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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.

New Card Needed: \_\_\_\_\_

NAME

Last

First

Middle

TITLE

D.O.B.

mm / dd / yyyy

EMPLOYED BY

Phone

CERTIFICATION REQUESTED AT

Installation Name

Have you ever been certified for Breath Testing in Arkansas?

\_\_\_\_ Yes

\_\_\_\_ No

If yes, Where?

Operator #

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