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

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:_____/_____/_____

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 _____ **CLEST ID No.**_____

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** _____