

**ARKANSAS DEPARTMENT OF HEALTH**  
**Women's Health**  
**Application for Lay Midwifery Apprentice Permit**

Last Name		First	Middle	Social Security Number		Date
Street		City		State	Zip	
Mailing Address, if different						
Home Phone ( )		Business Phone ( )		Other Phone (cellular, pager, etc.) ( )		
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Have you attended school, been licensed, or certified under a different name? If yes, what name(s) _____				<input type="checkbox"/> Yes <input type="checkbox"/> No
Highest Grade Completed	Date Completed	Name of High School	Address	State	Zip	
College or Vocational Training Name and Address of School		Dates Attended		Total Credit/ Clock Hours	Date of Diploma Or Certificate	
		From      To				
		From      To				
		From      To				
If you are not a high school graduate, do you Have an equivalency certificate?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, from where		Date	
Other Licenses Name of Trade or Profession		State	License Number		Expiration Date	
Have you ever had a license revoked in any health-related field? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify _____ _____ _____			Have you ever been convicted of a felony? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify _____ _____ _____			

I certify that all information given on this application is true and accurate.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

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Type or print the application and check thoroughly before submitting. An incomplete application will delay processing.

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**The following documentation must be included with the application:**

1. A copy of your high school diploma or equivalent.
2. Current documentation of a negative TB skin test, negative chest X-ray, or a valid health card.
3. Proof of rubella immunization or immune status.
4. Current certification by American Red Cross or American Heart Association to provide cardiopulmonary resuscitation to adults and infants.
5. Preceptor-Apprentice Agreement(s) signed by the supervising Midwife/Preceptor.

**Mail all forms and attachments to:**

FREEWAY MEDICAL BUILDING  
AR DEPT OF HEALTH, WOMEN'S HEALTH  
5800 WEST 10<sup>TH</sup>, SUITE 401, SLOT 16  
LITTLE ROCK, AR 72204