

ARKANSAS DEPARTMENT OF HEALTH

Women's Health

Apprentice Permit Renewal

Last Name	First	Middle	Date of Birth	Gender <input type="radio"/> Male <input type="radio"/> Female	Date
<i>It is your responsibility to notify us of any change in name or address</i>			Social Security Number		
Address (include Street, City, State, Zip)				Home Phone ()	
				Business Phone ()	
Mailing Address, if different from above				Other Phone (pager, etc.) ()	
Other Licenses Now Current Name of Trade or Profession		State	License Number	Expiration Date	
Have you ever had a license revoked in any health-related field? <input type="radio"/> Yes <input type="radio"/> No If yes, specify _____			Have you ever been convicted of a felony? <input type="radio"/> Yes <input type="radio"/> No If yes, specify _____		
<p>INSTRUCTIONS</p> <p>Type or print the application and review thoroughly before submitting. An incomplete application will delay processing. The following documentation must be included with the application:</p> <ol style="list-style-type: none"> 1. Copy of certificate in Cardio-Pulmonary Resuscitation (infant and adult) showing expiration date. 2. Current documentation of a negative TB skin test, negative chest x-ray, or a valid health card. 3. Current Preceptor-Apprentice Agreement. 4. Current Clinical Evaluation for Apprenticeship: <ol style="list-style-type: none"> a. Clinical Experience Documentation for Births as an Active Participant b. Clinical Experience Documentation for Births as a Primary Midwife c. Documentation of Acquisition of Clinical Knowledge and Skills <p align="center">Mail all forms and attachments to:</p> <p align="center"> FREEWAY MEDICAL BUILDING AR DEPT OF HEALTH, WOMEN'S HEALTH 5800 WEST 10TH, SUITE 401 LITTLE ROCK, AR 72204 </p>					