FOR OFFICE USE
EXP CREDIT_____
COMPLETION DATE_____
BY_____
REC'D_____
DATE_____
LICENSE #_____
ORG. DATE_____

HOSPITAL MAINTENANCE TRAINEE

RESTRICTED PLUMBING LICENSE

ARKANSAS DEPARTMENT OF HEALTH
PLUMBING & NATURAL GAS SECTION
4815 WEST MARKHAM STREET, SLOT # 24
LITTLE ROCK, ARKANSAS 72205-3867
PHONE (501) 661-2642 • FAX (501) 661-2671

NAME_____
Last First Middle

SOCIAL SECURITY _____**D.O.B.**_____

The agency is required to obtain your Social Security Number for the purpose of child support enforcement.
Except for its use in child support enforcement, your Social Security Number will not be used by the agency and will be held confidential.

HOME / CELL PHONE_____ **WORK PHONE**_____

MAILING ADDRESS_____

CITY_____ **STATE**_____

ZIP CODE _____ **COUNTY**_____ **EMAIL**_____

CANDIDATE'S BACKGROUND

FORMAL EDUCATION Please check: GED ☐ High School Diploma ☐ College Degree ☐

Have you ever pled guilty or nolo contendere or been convicted of a crime? YES_____ NO_____ (If YES, provide the date, the state and nature of the offence)_____

HOSPITAL FOR WHICH YOU WILL BE WORKING:

NAME_____

LOCATED AT _____**STREET**_____

CITY_____**STATE**_____**ZIP**_____

HOSPITAL MAINTENANCE SUPERVISOR OR MASTER PLUMBER UNDERWHICH YOU WILL BE WORKING

NAME_____ LICENSE #_____

Applicant, _____, hereinafter designated Applicant.
NAME

The applicant signing this application being duly sworn declared that the foregoing statements and attachments subscribed to by him/her are true to the best of his/her knowledge and that he/she personally signed this application.

SUBSCRIBED AND SWORN TO BEFORE THIS _____DAY

OF_____YEAR_____

SIGNATURE OF NOTARY_____

SEAL

STATE OF_____

COUNTY OF_____