



**HVAC/R SECTION**  
**ARKANSAS DEPARTMENT OF LABOR AND LICENSING**  
 900 W Capitol, Suite 400, Little Rock, Arkansas 72201  
 Phone 501-682-4500 TRS 800-285-1131  
[www.labor.arkansas.gov](http://www.labor.arkansas.gov)

**HVACR REGISTRANT APPLICATION**

PAYMENT OF \$25.00 MUST BE SUBMITTED WITH APPLICATION

*All Information is required for Application Processing. Incomplete Applications will be returned*

License Information			
<input type="checkbox"/> Registrant \$25.00			
Applicant Information			
Last Name:		First:	Middle Initial:
Street Address:		City:	State: Zip:
Mailing Address:		City:	State: Zip:
Phone:		Email Address:	
SSN:		DOB: (mm/dd/year)	
<b>ACT 820: (Check all that apply)</b> Are you <input type="checkbox"/> or your spouse <input type="checkbox"/> a current member of the U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you <input type="checkbox"/> or your spouse <input type="checkbox"/> a veteran of the U.S. Military?			
<b>Act 990: Have you been convicted of a felony?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, provide date of conviction name of court and the type of conviction below. (Do Not Provide Court Documents or Sentencing Agreements.)</i> Conviction Statute: _____ Date of Conviction: _____ Name of Court: _____ Probation Completion Date: _____			
<b>Act 725: any applicant can request an initial license fee waiver if: (Check All Applicable Boxes.)</b> <input type="checkbox"/> Receives Assistance through the Arkansas Medicaid Program <i>(Provide copy of current enrollment.)</i> <input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP) or the Special Supplemental Program for Women Infants and Children: <i>(Provide proof of current enrollment.)</i> <input type="checkbox"/> Temporary Assistance for Needy Families Program or the Lifeline Assistance Program. <i>(Provide proof of enrollment.)</i> <input type="checkbox"/> Approved for unemployment compensation in the last twelve (12) months <i>(Provide proof of benefits from the Department of Workforce Services.)</i> <input type="checkbox"/> Has an income that does not exceed two hundred percent (200%) of the federal poverty limit. <i>(Submit tax return for previous year.)</i>			
<b>Applicant/Employer Certification:</b> <input type="checkbox"/> My signature of this application acknowledges it is my responsibility to keep the HVAC/R Section of the Arkansas Department of Labor and Licensing advised of my current address, phone and employer.			
Employer Name:			
Designated License Holder Name:			
License#			
Street Address:		City:	State: Zip:
Mailing Address:		City:	State: Zip:
Phone:		Email Address:	
Employer Signature:			Date
Employer Printed Name & Title:			
Applicant Signature:			Date: