



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

HVACR LICENSE APPLICATION

PAYMENT MUST BE SUBMITTED WITH APPLICATION

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

License Information			
<input type="checkbox"/> Class A <input type="checkbox"/> Class B <input type="checkbox"/> Class C (Service Only) <input type="checkbox"/> Class D (Sheetmetal) <input type="checkbox"/> Class E (Refrigeration Only)			
License Fees: Class A: \$200.00 Class B \$150.00 Class C \$100.00 Class D \$150.00 Class E \$150.00			
Applicant Information			
Last Name:		First:	Middle Initial:
Street Address:		City:	State:
Mailing Address:		City:	Zip:
Phone:		Email Address:	
SSN:		DOB: (mm/dd/year)	
Name of Company:		Registrant #	
Mailing Address:		City:	State:
ACT 820: (Check all that apply) 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?			
Act 990: Have you been convicted of a felony? <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: _____			
Act 725: any applicant can request an initial license fee waiver if: (Check All Applicable Boxes.) <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>			
Applicant/Employer Certification:			
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.			
Work History			
Each Application must submit two (2) years of recent, verifiable, direct HVAC/R experience			
Employer Name:			
Address:		City:	State:
Phone:		Email: (if known)	
Employment Date From: (mm/dd/year)		To: (mm/dd/year)	

Description of Work Performed:			
Employer Name:			
Address:	City:	State:	Zip:
Phone:		Email: (if known)	
Employment Date From: (mm/dd/year)		To: (mm/dd/year)	
Description of Work Performed:			
Employer Name:		Address:	
Address:	City:	State:	Zip:
Phone:		Email: (if known)	
Employment Date From: (mm/dd/year)		To: (mm/dd/year)	
Description of Work Performed:			

I HEREBY AFFIRM THAT I HAVE AT LEAST TWO (2) YEARS OF EXPERIENCE AS AN HVAC CONTRACTOR OR HAVE WORKED IN THE HVAC BUSINESS FOR AT LEAST TWO (2) YEARS AND THAT ALL OF THE FACTS, STATEMENTS, AND ANSWERS CONTAINED HEREIN ARE TRUE.

APPLICANT SIGNATURE

THE APPLICANT SIGNING THIS APPLICATION, BEING DULY SWORN, DECLARES THAT THE FOREGOING STATEMENTS SUBSCRIBED TO BY HIM ARE TRUE AND TO THE BEST OF MY KNOWLEDGE PERSONALLY SIGNED THIS APPLICATION. SUBSCRIBED AND SWORN TO BEFORE ME

THIS _____ DAY OF _____, 20

SIGNATURE OF NOTARY _____

STATE OF _____

COUNTY OF _____ (SEAL)