



Arkansas State Board of Collection Agencies
900 West Capitol Avenue, Suite 400
Little Rock, AR 72201-9707
501-371-1434 Phone Number
501-372-5383 Fax Number

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RETROACTIVE LICENSE APPLICATION

License #

(A) AGENCY INFORMATION:

Agency Name

Doing business as (d/b/a)

Name to Appear on the License

Mailing Address

City State Zip Country

Mailing Address Phone # Fax #

Physical Location Street Address

City State Zip Country

Physical Location Phone # Fax #

(B) CONTACT PERSONS:

1. Licensing Email Address

Phone # Extension Fax #

Employer (If not agency name listed above)

2. Compliance Email Address

Phone # Extension Fax #

Employer (If not agency name listed above)

(C) RETROACTIVE INFORMATION:

Retroactive Effective Date Month Date Year

Agency Name as of Retroactive Date

(D) REQUIRED FEE OF \$10,000.00: (Made payable to the Arkansas State Board of Collection Agencies.)

Check, Money Order or Cashier's Check Number

(E) AFFIRMATION:

I hereby affirm that this application and its related documents are submitted in compliance with Arkansas Code Annotated §17-24-101 *et. seq* and the information provided herein is true, correct and complete.

Date
(Collection Agency Name)

(Signature)

(Printed Name)

(Title/Official Capacity)

ACKNOWLEDGMENT

State of

County of

Sworn to and subscribed before me on the day of , 2 .

(Notary Public)

(SEAL)

My commission expires on: