



HVAC/R SECTION
ARKANSAS DEPARTMENT OF LABOR AND LICENSING
 900 W Capitol, Suite 400, Little Rock, Arkansas 72201
 Phone 501-682-9201 TRS 800-285-1131
www.labor.arkansas.gov email: adll.hvac@arkansas.gov

HVACR REGISTRANT APPLICATION
PAYMENT OF \$25.00 MUST BE SUBMITTED WITH APPLICATION*
COMPLETE FORM IN ITS ENTIRETY. INCOMPLETE FORMS WILL BE RETURNED

License Information			
<input type="checkbox"/> Registrant \$25.00* If you check yes to ACA §17-3-102 do not submit payment until instructed.			
EMPLOYEE INFORMATION			
Last Name:	First:	Middle Initial:	
Street Address:	City:	State:	Zip:
Mailing Address:	City:	State:	Zip:
Phone:	Email Address:		
SSN:	DOB: (mm/dd/year)		
Act 820 (check all that apply)			
Are you <input type="checkbox"/> or your spouse <input type="checkbox"/> a current <input type="checkbox"/> or retired <input type="checkbox"/> of the U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No			
A.C.A §17-3-102: Have you been convicted of a felony? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide date of conviction, name of court and the type of conviction below.			
<u>*IF YOU CHECK YES TO THIS QUESTION, COMPLETE QUESTIONS BELOW. SUBMIT APPLICATION WITHOUT PAYMENT.</u>			
Conviction Statute: _____			
Date of Conviction: _____			
Name of Court: _____			
Probation Completion Date: _____			
EMPLOYER INFORMATION			
Employer Business Name:			
Responsible License Holder Name:			
License#	Expiration Date:		
Street Address:	City:	State:	Zip:
Mailing Address:	City:	State:	Zip:
Phone:	Email Address:		
Employer Certification:			
<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 Signature:		Date:	
Employer Printed Name & Title:			
Employee Signature:		Date:	