



# ARKANSAS STATE POLICE

## Concealed Handgun Carry License New or Renewal Application Certification of Training

*(Please print clearly and provide all requested information)*

**Fax this properly completed form to (501) 618-8555  
or e-mail to [chclinfo@asp.arkansas.gov](mailto:chclinfo@asp.arkansas.gov)**

**NOTICE:** Knowingly providing false information on this form could result in criminal prosecution or revocation or non-issuance of an Arkansas Concealed Handgun Carry License.

The applicant, by completing this form, swears or affirms that he/she has successfully completed the required training for an Arkansas concealed handgun carry license pursuant to Arkansas Code Annotated §§5-73-301 et seq. and the Arkansas State Police Concealed Handgun Carry License Rules.

The instructor(s), by completing this form, swears or affirms that he/she has successfully administered the required training for an Arkansas concealed handgun carry license pursuant to Arkansas Code Annotated §§5-73-301 et seq. and the Arkansas State Police Concealed Handgun Carry License Rules, **including "live fire."**

I hereby state under oath that the representations made herein are true and correct.

Completion Date of Training: \_\_\_\_\_ CHCL # \_\_\_\_\_  
(if renewal)

Qualified with Semiautomatic \_\_\_\_\_ Revolver \_\_\_\_\_

Confirmation # (from on-line application only) \_\_\_\_\_  
(if applicable)

Name of the Applicant: \_\_\_\_\_  
PRINT CLEARLY (First/MI/Last Name)

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_  
(First/MI/Last Name) (Month/Day/Year)

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*Please write clearly (do not separate form)*

Name of Instructor: \_\_\_\_\_ Inst # \_\_\_\_\_  
(First/MI/Last Name)

Signature of Instructor: \_\_\_\_\_ Date: \_\_\_\_\_  
(First/MI/Last Name) (Month/Day/Year)

**INSTRUCTORS ONLY:** Instructors who apply for new or renewal of their Arkansas concealed handgun carry license should, in lieu of a training certificate, send in a copy of their current firearm safety training instructor registration certificate issued by the Department.