ARKANSAS DEPARTMENT OF HEALTH
COSMETOLOGY SECTION
4815 West Markham, Slot 8
Little Rock, AR 72205
(501) 682-2168

REQUEST FOR HOURS

SCHOOL NAME: ____

SCHOOL ADDRESS: ____

COURSE NAME: ____________________ HOURS COMPLETED: ____________

DATE ENROLLED: __________________ DATE DROPPED: ________________

STUDENT'S NAME: ____

STUDENT'S SSN: ___________________ PHONE#: ____________________

I AM REQUESTING THE ABOVE INFORMATION BE SENT TO:

SCHOOL NAME: ____

SCHOOL ADDRESS: ____

FAX#:________________________ EMAIL:__________________________

COURSE NAME: ____

ANTICIPATED ENROLLMENT DATE: _______________________________

UPON DEPARTMENT VERIFICATION, THE ABOVE INFORMATION WILL BE SENT TO THE REQUESTED SCHOOL WITHIN 5 DAYS. THIS INFORMATION MUST BE MAILED TO THE ABOVE ADDRESS. TELEPHONE INQUIRES ARE NOT ACCEPTED.

PLEASE BE ADVISED IF YOU HAVE NOT MET YOUR FINANCIAL OBLIGATION THE SCHOOL IS NOT REQUIRED TO RELEASE YOUR HOURS.

STUDENT SIGNATURE: ____________________________ DATE: ____________