Arkansas Department of Education

Four State Capitol Mall, Room 106B, Little Rock AR 72201

Licensure Fee Refund Request Form

Please complete this form and fax it to 501-682-4898 or mail it to the Office of Professional Licensure at the above address.

Date Paid: _____ Last (4) of social security number XXX-XX- _____

Contact Information:

Name : _____

Address: _____

_____

Email : _____

Phone: _____

School District:_____

Please note:
In order to improve customer service, we may need to contact you to gather further information concerning the processing of your refund request.

Please provide a detailed explanation of the reason why you are asking for a refund:

_____

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Signature:_____ Date:_____

March 2012