All Correspondence Courses must have a proctored exam to be valid. Form must be typed or printed.

**LICENSEEE’S INFORMATION**

Name of Licensee: _______________________________________________________
Licensee’s License # ______________________________________
Resident Address: ________________________________________________________
   Street or P.O. Box   City or State   Zip
Business Phone # __________________________________
Producer Signature___________________________  Date _______________________

**PROCTOR INFORMATION:**

Proctors Name: ______________________________________________________
Proctors Address: ______________________________________________________
Proctors Phone Number: _______________________________________________
Proctors Driver’s License # ______________________ State of Issue __________
Start Time of Exam ____________ End Time of Exam ______________
Date of Completion of Examination_______________________________________
Location of Examination ________________________________________________

**ATTESTATION:**

I do hereby solemnly attest that I proctored the above correspondence examination provided to the above name licensee and that the examination was provided as instructed by the Course Provider. I assure the Commissioner that no attendee was permitted to use study materials or have assistance during the exam. Further, I am not part of, or aware of any efforts to circumvent the requirements of the proctored examination, and I have no special interest to ensure the licensee passes the examination. I understand that this affidavit is provided under oath or affirmation, and that false information shall be grounds for possible Arkansas Insurance Code or Rule penalties.

_____________________________   _________________________
Signature of Proctor      Date

Once Licensee has tested and Proctor has completed form—Provider completes and sends to Department

**CONTINUING EDUCATION PROVIDER INFORMATION** (Completed by Provider only)

Course Name ______________________________________ Course # ______________
Provider Name _____________________________________Provider’s # ____________

Signature of Provider Responsible Contact

_____________________________   _________________________
Date: 18