



**ARKANSAS STATE POLICE
SCHOOL SECURITY DEPARTMENT
(Grades PRE-K through 12)
RECOGNITION APPLICATION**

FOR OFFICE USE ONLY EFFECTIVE 11-2017 DATE PROCESSED _____ PROCESSED BY _____
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NOTICE: Information contained on this application is considered a public record and may be released under the Freedom of Information Act. Under penalty of A.C.A. § 5-53-103, knowingly giving a false statement or submitting a false document constitutes a Class A Misdemeanor.

NAME OF SCHOOL: _____

FOR OFFICE USE ONLY: CMPY-SSD License Number
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SCHOOL PHYSICAL LOCATION ADDRESS:

_____	_____	_____	_____
Street/P.O. Box	City	County	State/ZIP

SCHOOL MAILING ADDRESS:

_____	_____	_____	_____
Street/P.O. Box	City	County	State/ZIP

SCHOOL OFFICE CONTACT PERSON: _____ SCHOOL PHONE: (____) _____

SCHOOL WEBSITE ADDRESS: _____

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IF BEING RECOGNIZED AS A SCHOOL SECURITY DEPARTMENT PLEASE COMPLETE THE FOLLOWING:

NAME OF SCHOOL: _____

NAME OF SUPERINTENDENT: _____

EMAIL ADDRESS OF SUPERINTENDENT: _____

I the undersigned hereby affirm that the applicant listed on this application is allowed to provide service to our school district as a School Security Department.

_____	_____	_____
Signature of School Superintendent	School District	Date

