

**DEPARTMENT OF ARKANSAS STATE POLICE
CONCEALED HANDGUN CARRY LICENSE
FIREARMS SAFETY TRAINING INSTRUCTOR
RELEASE OF INFORMATION**

I consent to the following information about me appearing on the Arkansas State Police website regarding concealed handgun carry license firearms safety training instructors registered with the Arkansas State Police:

Last	First	Middle	Jr., Sr., or III (if applicable)
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Address: _____

City	State	ZIP
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Instructor # _____

County or counties in which you offer classes: _____

Telephone numbers (provide at least one or an e-mail address)

Work: _____

Home: _____

Cell: _____

E-mail address(es): _____

This release is continuing in force and effect unless revoked in writing by the instructor delivered to Arkansas State Police, CHCL Section, 1 State Police Plaza Drive, Little Rock, AR 72209

Signature: _____ Date: _____
(First/MI/Last Name) (Month/Day/Year)