Arkansas State Board of Collection Agencies
900 West Capitol Avenue, Suite 400
Little Rock, AR 72201-9707
501-376-9814 Phone Number
501-372-5383 Fax Number

RETROACTIVE LICENSE APPLICATION

License # ______

(A) AGENCY INFORMATION:

Agency Name ______

Doing business as (d/b/a) ______

Name to Appear on the License ______

Mailing Address ______

City ______ State ______ Zip ______ Country ______

Mailing Address Phone # ______ Fax # ______

Physical Location Street Address ______

City ______ State ______ Zip ______ Country ______

Physical Location Phone # ______ Fax # ______

(B) CONTACT PERSONS:

1. Licensing ______ Email Address ______

Phone # ______ Extension ______ Fax # ______

Employer (If not agency name listed above) ______

2. Compliance ______ Email Address ______

Phone # ______ Extension ______ Fax # ______

Employer (If not agency name listed above) ______

(C) RETROACTIVE INFORMATION:

Retroactive Effective Date Month ______ Date ______ Year ______

Agency Name as of Retroactive Date ______

(D) REQUIRED FEE OF $10,000.00: (Made payable to the Arkansas State Board of Collection Agencies.)

Check, Money Order or Cashier's Check Number ______

(E) AFFIRMATION:

I hereby affirm that this application and its related documents are submitted in compliance with Arkansas Code Annotated §17-24-101 *et. seq* and the information provided herein is true, correct and complete.

Date

(Collection Agency Name)

(Signature)

(Printed Name)

(Title/Official Capacity)

ACKNOWLEDGMENT

State of

County of

Sworn to and subscribed before me on the day of , 2 .

(Notary Public)

(SEAL)

My commission expires on: