Arkansas Department of Finance and Administration
AMERICAN RESCUE PLAN ACT
CORONAVIRUS STATE FISCAL RECOVERY FUNDS
COMPLETED TESTING ROSTER

Subrecipient Name_____

Employee Name	Employee Address	Employee Social Security Number	Employee Date of Hire	Employee Number	Type of Test Completed	Name of Manufacturer for Each Test	US FDA EUA Number for Each Test	Cost of Test	Testing Schedule (Weekly, Monthly, Semi-annually)

Important – Read before signing.
By signing this form, you certify under penalty of perjury, based on information and belief formed after reasonable inquiry, the statements and information contained in this form and the attached documents are true, accurate, and complete.

Authorized Representative Signature_____

Authorized Representative:(please print) _____

Title: _____

Date signed: _____

Mail Form to:
Arkansas Department of Finance and Administration

Attn: Office of Accounting – ARPA 2nd Floor
P. O. Box 3278
Little Rock, AR 72203-3278

Email Form to:
COVID19TESTING@DFA.ARKANSAS.GOV