PUBLIC HEALTH DIVISION
Health Care Regulation and Quality Improvement Section
Health Facility Licensing and Certification Program
healthoregon.org/hflc

Birthing Center License Form

Type of Action			
New Facility*	☐	Ownership Change*	☐
License #	☐	Other (Specify):	☐
License Renewal* **(due 12/1)**	☐	Effective Date of Change:	
Name/Address Change	☐		

* Fee Payment Required (Flat Fee $750.00)

Facility Information		
Facility Legal Name:		
Facility DBA Name (if applicable):		
Facility Physical Address, City, State & ZIP:		
Phone:	Fax:	County:
Facility Mailing Address (if different from above):		
Facility Email:		
Name of Administrator & Phone:		
Administrator Email:		
Emergency Contact Person & Phone:		
Emergency Contact Person Email:		
Days and Hours of Operation:		

Owner Information (If partnership or corporation, list each person having 5% or more interest on an additional page)			
Individual ◯	Partnership ◯	Health District ◯	State ◯
Corporation ◯	County ◯	City ◯	Church ◯
Ownership Type: For Profit ◯ Non- Profit ◯		Tax ID#:	
Name of Owner(s):			
Address, City, State & ZIP of Owner(s):			
Phone:	Fax:	County:	

I declare, under penalties of perjury, that I have examined this application and all attachments and that to the best of my knowledge and belief, this information is true, correct and complete. I will notify Health Care Regulation and Quality Improvement, in writing, of any changes in this information within 30 days of any such change.

Administrator's Signature	***Print Name***
Print Title	***Date (mm/dd/year)***

Make check payable to: **Oregon Health Authority**
Mail payment to: **HFLC**
PO Box 14260
Portland, OR 97293

Questions about this application?
Phone: 971-673-0540
Email:mailbox.hclc@odhsoha.oregon.gov

HCRQI Office Use Only

Effective date of initial licensure: _____ Initials: _____ Date: _____

Renewal Licensure/Change: Approved: _____ Denied: _____ Withdrawn: _____

Initials: _____ Date: _____

CASH OFFICE: QC **793** initial/QC **795** renewal