



**Department of Human Services
Health Care Licensure and Certification**
800 NE Oregon Street, Suite 305
Portland, OR 97232-0450
(971) 673-0540; Fax (971) 673-0556

**APPLICATION FOR RENEWAL OF PROVISIONAL CERTIFICATION AS A
HEMODIALYSIS TECHNICIAN**

**If you need this document in an alternate format, please contact Health Care
Licensure and Certification at (971) 673-0540.**

Please type or print.

**Please answer all questions completely and sign the application in the space
provided.**

NAME:

Last	First	Middle	Maiden
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ADDRESS:

Number & Street	Apt #	City	State	Zip
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Telephone Number (____) ____-____ DATE OF BIRTH: ____/____/____
 ____unlisted

**APPLICATION FOR RENEWAL OF PROVISIONAL CERTIFICATION AS A
HEMODIALYSIS TECHNICIAN (continued)**

LIST YOUR HEMODIALYSIS EMPLOYERS, STARTING WITH THE MOST
RECENT:

Facility Name	Location	Dates of Employment	
		From	To
_____	_____	__/__/__	__/__/__
_____	_____	__/__/__	__/__/__
_____	_____	__/__/__	__/__/__
_____	_____	__/__/__	__/__/__

Please provide documentation of the hemodialysis training you have received. This should include classroom as well as clinical training. Attach additional pages to the application if necessary.

DATE	TITLE	SPONSOR	TIME
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please answer all of the following questions. **“Yes” responses require a detailed written explanation. Use another page and staple it to the application.**

1. Do you have a physical, mental, or emotional condition(s) which may impair your ability to perform certified hemodialysis technician (CHDT) duties with the required skill and safety? **YES NO**
2. Have you ever been arrested, charged with, entered a plea of guilty, no contest, been convicted of, or sentenced for any criminal offense, either a misdemeanor or felony in any state? **YES NO**

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3. Have you ever been investigated for any type of abuse in any state?
YES NO
4. Have you ever been found guilty of violating any state and/or federal law and/or rule regulating health care practice?
YES NO
5. Are any disciplinary actions **pending** against your CHDT certificate or its equivalent in any state or US jurisdiction?
YES NO
6. Have any disciplinary actions **been taken** against your CHDT certificate or its equivalent in any state or US jurisdiction?
YES NO
7. Have you ever suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of health care?
YES NO
8. Do you use, or have you used in the last five(5) years any chemical substance(s) that would in any way impair or limit your ability to perform as a CHDT with the required skill and safety? **YES NO**
9. Are you currently engaged in the illegal use of any controlled substance?
YES NO
10. Have you ever been found in any civil, administrative, or criminal proceeding to have:
- a. Possessed, used, prescribed for use, or distributed controlled substances or prescription drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or prescription drugs, violated any drug law or prescribed a controlled substances for yourself? **YES NO**
 - b. Committed any act involving dishonesty or corruption?
YES NO

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c. Violated any state or federal law or rule regulating the practice of a health care profession? **YES NO**

11. Have you ever had any certificate, license, registration or other privilege to practice a health care profession denied, revoked, suspended, restricted, reprimanded, or censured? **YES NO**

12. Have you ever been placed on probation by a state, federal or foreign authority? **YES NO**

Please provide documentation of continuing education. This can include in-services, conferences, meetings, workshops, etc. Include the date of the event, the title of the event, the event sponsor, the length of time of each event, and any Continuing Education Units (CEU's) earned by your attendance. Attach additional pages to the application if necessary.

DATE	TITLE	SPONSOR	TIME

A PROVISIONAL CERTIFICATE IS VALID FOR SIX (6) MONTHS.
A PROVISIONAL CERTIFICATE IS RENEWABLE ONE (1) TIME.

Falsifying an application, supplying misleading information, or withholding information is grounds for denial or revocation of certification. I hereby certify that I am the above named individual and that the information given is true and correct. Health Care Licensure & Certification will conduct a criminal record check through the Law Enforcement Data System (LEDS). Signature on this form indicates my consent for that criminal record check.

Applicant Signature

Date Signed