

# Oregon Health Licensing Agency



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 Salem, OR 97301-1287  
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 Fax: (503) 370-9004  
 Website: <http://www.oregon.gov/ohla>  
 E-mail: [ohla.info@state.or.us](mailto:ohla.info@state.or.us)

## Customer Information Update

**IMPORTANT:** For all transactions listed below, you must provide one acceptable form of photographic identification. See Oregon Administrative Rule 331-030-0000(8) and (10). Legible (clear) photocopy of front and back if submitted by mail.

RENEWAL\*                       LATE FEE\*                       REPLACEMENT\*

\*Fees apply – Visit [www.oregon.gov/OHLA](http://www.oregon.gov/OHLA) for listing of fees.

CHANGE OF HOME ADDRESS                       CHANGE OF EMPLOYMENT

NAME CHANGE:  
 PRINT PREVIOUS NAME \_\_\_\_\_ (List new name below)

**In addition to one form of acceptable photographic identification, you must also provide approved documentation filed in a court with appropriate jurisdiction.**

OTHER – please explain:

LICENSE / CERTIFICATION / REGISTRATION #: - -	EXPIRATION DATE (MM/DD/YYYY):
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LICENSE / CERTIFICATION / REGISTRATION #: - -	EXPIRATION DATE (MM/DD/YYYY):
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NAME: LAST	FIRST	MIDDLE INITIAL
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RESIDENTIAL PHYSICAL ADDRESS (Required):

CITY:	STATE:	ZIP:	DATE OF BIRTH:	SOCIAL SECURITY #(Required)
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MAILING ADDRESS (if different from physical address):

CITY:	STATE:	ZIP:
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PHONE: <input type="checkbox"/> HOME <input type="checkbox"/> CELL	BUSINESS TELEPHONE:	E-MAIL:
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### Current Employer Information

PLEASE INDICATE:  EMPLOYEE     INDEPENDENT CONTRACTOR     NOT CURRENTLY EMPLOYED

NAME OF FACILITY/COMPANY:	FACILITY LICENSE # (if licensed by OHLA): - -
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ADDRESS OF FACILITY/COMPANY:	INDEPENDENT CONTRACTOR REG. # (if applicable): - -
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CITY:	STATE:	ZIP:	TELEPHONE #:
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**Method of Payment** - (DO NOT WRITE IN THIS SPACE – OFFICIAL USE ONLY) INITIALS \_\_\_\_\_  OTC  VERIFIED ID  APPROVAL CODE/CK#: \_\_\_\_\_

Please check one:  Cash  Check  Money Order  Purchase Order  Credit Card (see below)

Type of Credit Card:  Visa  MasterCard  Discover (Cardholder must either be the applicant or be present at the time application is submitted) **DO NOT FAX OR EMAIL CREDIT CARD INFORMATION**

Name on Card: \_\_\_\_\_

Card Number: \_\_\_\_\_ Exp: \_\_\_\_\_ Authorized Amount: \$ \_\_\_\_\_

Cardholder Signature: \_\_\_\_\_

## Customer Information Update, *continued*

### Continuing Education – Self Attestation

I hereby attest that I have acquired \_\_\_\_\_ continuing education contact/credit hours required as a condition of license renewal and that adequate proof of attainment is available for audit or investigation by the Oregon Health Licensing Agency.

**Applicant Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

### CPR/First Aid/Blood Borne Pathogens Training – Self Attestation

As a condition of license renewal I hereby attest that I hold a current certification in:

- Cardiopulmonary Resuscitation (CPR) (**Required for Athletic Trainers, Tattoo Artist, Body Piercers and Direct Entry Midwives**)  
 First Aid Training; and  Blood Borne Pathogens Training (**Required for Tattoo Artist and Body Piercers**)  
 Neonatal Resuscitation (**Required for Direct Entry Midwives**)

**And** that adequate proof of current certification is available for audit by the Oregon Health Licensing Agency.

**Applicant Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

### Replacement Request

I have not received my license, certificate or registration.  My license, certificate or registration was lost, stolen or destroyed. **COPY OF PHOTO IDENTIFICATION REQUIRED. See 331-030-0000 (8) and (10). Legible (clear) photocopy of front and back if submitted by mail.**

### Disciplinary Action / Criminal Record

Are you now, or have you ever been, the subject of any active or inactive disciplinary action or voluntary resignation of a certificate, license, permit or registration imposed by any licensing or regulatory authority in this or any other state? (Disciplinary action includes, but is not limited to, probation, suspension, civil penalty, or other sanction limiting in any way, a license, certificate, registration or permit.)

**NO**  **YES** If yes, please explain:

Have you been convicted of a misdemeanor (other than traffic violation), or a felony, since your last renewal or information update with the agency?

**NO**  **YES** If yes, please explain:

Are you currently on parole or probation?  **NO**  **YES** If yes, you must provide a letter of release from your parole/probation officer authorizing you to obtain an authorization to practice.

As part of your application for initial or renewed occupational or professional license, certification, or registration issued by the Oregon Health Licensing Agency, you are required to provide your Social Security number to the Oregon Health Licensing Agency. This is mandatory. The authority for this requirement is ORS 25.785, ORS 305.385, 42 USC §405(c)(2)(C)(i), and 42 USC § 666(a)(13). Failure to provide your Social Security number will be a basis to refuse to issue or renew the license, certification, or registration you seek. This record of your Social Security number is used for child support enforcement and tax administration purposes (including identification) only, unless you authorize other uses of the number. Although a number other than your Social Security number appears on the face of the licenses, certificates, or registrations issued by the Oregon Health Licensing Agency, your Social Security number will remain on file with the Oregon Health Licensing Agency. I have examined this application and certify that it is true, correct, and complete. I understand that knowingly making a false statement on this application will be cause for denial, suspension, or revocation of certification. I have enclosed the required fees and documentation. I understand my application may be subject to a criminal background check. I authorize the use of my Social Security number for that purpose. If registered to practice in Oregon, I will comply with the laws and rules adopted by the Oregon Health Licensing Agency.

**Applicant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

ORS 181.534, 676.608, and 676.612 authorize the Oregon Health Licensing Agency to conduct criminal background checks and the agency requests that you voluntarily provide your Social Security Number for this purpose. Failure to provide your Social Security Number for this purpose will not be used as a basis to deny your application, or to deny you any right, benefit or privilege provided by law. If you consent to the use of your Social Security Number by the Oregon Health Licensing Agency for this purpose, it may be used only for criminal records checks. I hereby voluntarily consent to disclose my Social Security Number to the Oregon Health Licensing Agency for criminal background checks.

**Applicant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_