HEALTH LICENSING OFFICE
Behavior Analysis Regulatory Board
1430 Tandem Ave. NE, Suite 180, Salem OR 97301-2192
Phone: 503-378-8667 | Fax: 503-370-9004
www.healthoregon.org/hlo | Email: hlo.info@state.or.us

Print Form

INTERVENTIONIST REGISTRATION APPLICATION

1. Applicant Information

APPLICANT NAME: LAST	FIRST	MIDDLE INTIAL

RESIDENTIAL PHYSICAL ADDRESS **(REQUIRED)**		
CITY	STATE	ZIP

MAILING ADDRESS (IF DIFFERENT FROM RESIDENTIAL ADDRESS)		
CITY	STATE	ZIP

PHONE: ☐ HOME ☐ CELL	BUSINESS TELEPHONE	EMAIL

GENDER ☐ Female ☐ Male	BIRTHDATE	SOCIAL SECURITY NUMBER or TAX IDENTIFICATION NUMBER (**REQUIRED**)

- Have you ever been known under any other name?
  ☐ **No** ☐ **Yes –** If yes, list full name(s):

- Do you hold or have you previously held licensure, certification or registration with the Health Licensing Office or any other state? ☐ **No** ☐ **Yes** - If yes, please list information below.

State:	Lic./Cert./Reg.#	Expiration:
State:	Lic./Cert./Reg.#	Expiration:
State:	Lic./Cert./Reg.#	Expiration:
State:	Lic./Cert./Reg.#	Expiration:

2. Supervisor Information *(if available at time of application)*

SUPERVISOR'S NAME:	SUPERVISOR'S BARB or HCP LICENSE#:

3. ***(Complete This Section Only If Submitting Payment By Mail)***

Method Of Payment For Application Fee = $75; Registration Fee = $100

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: _____

Do not write in this section – Official use only

Initials_____ ☐ OTC ☐ ID Verified ☐ BACB Cert. Verified ☐ LEDS Completed ☐ HSD/GED Received

☐ Pathway 1 Documents Received ☐ Pathway 2 Documents Received

4. Individual Records Questions: Please accurately answer all of the questions below. The Office may review your information through the Law Enforcement Data System, other governmental agencies, and private vendors to confirm the accuracy of the information. Any misrepresentation or failure to disclose information may result in disciplinary action.

- Are you now, or have you ever been, the subject of any active or inactive disciplinary action or voluntary resignation of a professional license, certificate, registration or permit imposed by a licensing or regulatory authority in this or any other state? Disciplinary action includes, but is not limited to, probation, suspension, civil penalty, or any other sanction limiting, in any way, a license, certificate, registration or permit. ☐ **Yes** ☐ **No** If yes, please explain: ***(attach additional pages if necessary)***

- Have you ever been convicted of a misdemeanor or felony? ☐ **Yes** ☐ **No**
  If yes, please list **all** convictions, including the charges as stated in the court documents and year convicted ***(attach additional pages if necessary)*.**

	Year Convicted

- As of today are you on probation or parole? ☐ **Yes** ☐ **No** If yes, you **must** provide a letter of release from your probation or parole officer authorizing you to obtain an authorization to practice. If you are on bench probation, or probation with the court, you must provide documentation of your conditions of the probation.

As part of your application for initial or renewed occupational or professional license, certification, or registration issued by the Health Licensing Office, you are required to provide your Social Security number (SSN) to the Office. This is mandatory. The authority for this requirement is ORS 25.785, ORS 305.385, 42 USC §405(c)(2)(C)(i), 42 USC § 666(a)(13), and 41 CFR 61.7. Failure to provide your SSN will be a basis to refuse to issue or renew the license, certification, or registration you seek. This record of your SSN is used for child support enforcement and tax administration purposes (including identification). The HLO will use your SSN for these purposes only, unless you authorize other uses of the number. Your SSN will remain on file with the Office.

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 my license, certification or registration. I have enclosed the required fees and documentation.

Applicant Signature:	**Date:**

ORS 181.534, 670.280, 676.800, and 676.612 authorize the Health Licensing Office to conduct criminal background checks and the office requests that you voluntarily provide your Social Security number for this purpose. I understand my application may be subject to a criminal background check.

Before issuing a default final order, the Health Licensing Office must determine the military status of a Respondent, under 50 USC App § 521(b) (Supp. 2005). Your Social Security Number may be used in order to verify your military status (or lack thereof).

If any disciplinary action is taken against your license, certification, or registration, your Social Security Number may be reported to the federal Health Care Integrity and Protection Data Bank (NPDB) under Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986 (Title IV); Section 1921 of the Social Security Act (Section 1921); Section 1128E of the Social Security Act (Section 1128E); and their implementing regulations found at 45 CFR Part 60.

I hereby voluntarily consent to disclose my Social Security number to the HLO for criminal background checks, verification of military status, and reports to the Health Care Integrity and Protection Data Bank. Failure to provide your Social Security number for these purposes 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 HLO for these purposes, it may be used only for these purposes.

Applicant Signature:	**Date:**

5. Affirmative Action – Voluntary Question

The State of Oregon has an Affirmative Action Policy. If you choose to provide this information, it will help us evaluate the effectiveness of our affirmative action programs. This information will also be used in the aggregate (i.e. as a whole, not individually) for research and statistical purposes. It will not be tied specifically or directly to your licensing information.

Ethnic Background *(check only one)*

☐ (A) **Asian or Pacific Islander**: Persons having origins in any of the peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. This area includes, for example, China, Japan, Korea, the Philippine Islands and Samoa.

☐ (B) **African American** *(not of Hispanic origin)*: Persons having origins in any of the Black racial groups of Africa.

☐ (H) **Hispanic**: Persons of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish cultures or origin, regardless of race.

☐ (I) **American Indian or Alaskan Native**: Persons having origins in any of the original peoples of North America, and who maintain cultural identification through tribal affiliation or community recognition.

☐ (W) **Caucasian** *(not of Hispanic origin)*: Persons having origins in any of the original peoples of Europe, North Africa or the Middle East.

REQUIREMENTS FOR BEHAVIOR ANALYSIS INTERVENTIONIST REGISTRATION

☐ Submit a completed application form prescribed by the Board, which must contain the information listed in OAR 331-030-0000 and be accompanied by payment of the required application fees = **$75** *(see method of payment section above)*;

☐ Submit one form of acceptable ***photographic*** identification as outlined in OAR 331-030-0000(10), ***which must include applicant's current legal name***: Front and back of legible (clear) photocopies if submitted by mail; *driver license, state ID card, passport or military ID card;*

☐ Submit documentation of a high school diploma or General Educational Development (GED) certificate or a degree from a post-secondary institution;

☐ Pass a fingerprint-based nationwide criminal records check pursuant to OAR 331-030-0004;

☐ Submit required registration fee = **$100** *(see method of payment section above)*; **and**

☐ Submit documentation of 40 hours of professional training in applied behavior analysis on a form prescribed by the Office in the following knowledge and skill areas, as verified by an individual listed in ORS 676.802(2)(a-h) or licensed by the Board:

(a) Professional and ethical issues;
(b) Foundational knowledge of behavioral change principles;
(c) Assessment;
(d) Implementation of prescribed intervention plans;
(e) Data Collection and documentation.

(See Verification of Professional Training form)

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Print Form

Interventionist Supervision Agreement (Page 1 of 2)

This form identifies the responsibilities of the Behavior Analysis Interventionist and the supervising Behavior Analyst, Assistant Behavior Analyst, or Licensed Health Care Professional. Both the applicant and supervisor must sign this document. A copy this agreement must be submitted to the HLO and provided to the parent or guardian of each of the interventionist's clients, and must be maintained by the Registered Interventionist for a period of at least five years as outlined in OAR 824-040-0010.

1. Interventionist Information

INTERVENTIONIST'S NAME: LAST	FIRST	MIDDLE INTIAL	DATE

2. Supervisor Information

SUPERVISOR'S NAME: LAST	FIRST	MIDDLE INTIAL	DATE

SUPERVISOR'S PROFESSIONAL LICENSE:

☐ BEHAVIOR ANALYST ☐ ASSISTANT BEHAVIOR ANALYST

☐ HEALTH CARE PROFESSIONAL (HCP) - TITLE: _____

SUPERVISOR'S BARB or HCP LICENSE # _____

EMPLOYER:

EMPLOYER PHYSICAL ADDRESS:

CITY:	STATE:	ZIP:

PROPOSED DATES OF SUPERVISION:

FROM: TO:

WHERE WILL SUPERVISION TAKE PLACE? ☐ SUPERVISOR'S OFFICE ☐ INTERVENTIONIST'S OFFICE

☐ OTHER: EXPLAIN

NAME OF FACILITY WHERE SUPERVISION WILL TAKE PLACE:

ADDRESS OF FACILITY *(PHYSICAL LOCATION)*:

CITY:	STATE:	ZIP:

A Copy Of This Form Must Be Provided To The Parent Or Guardian Of The Client

Interventionist Supervision Agreement (Page 2 of 2)

3. Responsibilities

Interventionist agrees that:

My title will be ***Registered Behavior Analysis Interventionist*** and that I am **not** permitted, under Oregon Law, to be called or represent myself as a Licensed Behavior Analyst, Licensed Assistant Behavior Analyst, or Licensed Health Care Professional;

I will provide a copy of this signed agreement to the Health Licensing Office, and to each client's parent or guardian;

I will complete a competency assessment with one of my supervisors and retain a copy of the assessment in my files;

I will maintain a log of ongoing training and supervision on the form available on the Office's website, or on the supervisor's form that contains all the same information;

I will notify the Office in writing within 10 business days if they are no longer being supervised or has a change in supervision;

I will follow the Standards of Practice, Professional Methods and Procedures as specified in **OAR 824-60-0010**, and understand that failure to comply with these standards may constitute unprofessional conduct which is subject to discipline under **ORS 676.805** and **ORS 676.992**; and

I will provide any and all information to my supervisor, and to the HLO, to ensure that protocols set-forth in Oregon Administrative Rules regulating my duties, responsibilities and services as an interventionist and as a supervisee, including the protocols set-forth in this agreement for the provision of my supervision, and agree to obtain prior approval of any modifications to this agreement.

By signing below, I certify that the information provided in this document is true and correct to the best of my knowledge. I agree to work under this supervision agreement as described above.

Interventionist Signature:	**Date:**

Supervising Behavior Analyst, Assistant Behavior Analyst, Health Care Professional agrees that:

I will ensure that a copy of this agreement is provided to the parent or guardian of each client receiving independent service delivery from the interventionist that is subject to this agreement;

I will complete a competency assessment on the interventionist subject to this agreement;

I will provide ongoing training and supervision to the interventionist after beginning independent client service delivery;

I will maintain oversight, as defined in OAR 824-010-0005(12), of the interventionist for a minimum of two hours prior to independent service delivery with any new client, which can be met through training;

I will provide a combination of direct and indirect supervision for at least 5 percent of the interventionist's service hours;

I will provide direct supervision at least once per calendar month in the months when services were provided; and

I will evaluate the interventionist subject to this agreement at least once a year after initial competency assessment on the form available on the Office's website or on another evaluation form with the same information.

By signing below, I certify that the information provided in this document is true and correct to the best of my knowledge. I agree to work under this supervision agreement as described above.

Supervisor Signature:	**Date:**

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INTERVENTIONIST VERIFICATION OF PROFESSIONAL TRAINING

Pursuant to 824-030-0040, ***40 hours*** of professional training in applied behavior analysis must be verified by an individual listed in ORS 676.802(2)(a-h) or licensed by the Board.

Verification Information

PRINTED NAME OF APPLICANT:
LAST FIRST MIDDLE INITIAL

PRINTED NAME OF INDIVIDUAL VERIFIYING TRAINING:
LAST FIRST MIDDLE INITIAL

INDIVIDUAL'S LICENSURE CREDENTIAL:

☐ Behavior Analyst or Assistant Behavior Analyst licensed with the Behavior Analysis Regulatory Board (BARB), or

☐ Licensed Health Care Professional listed in ORS 676.802(2)(a-h).

INDIVIDUAL'S: ☐ BARB LICENSE #; OR ☐ HEALTH CARE PROFESSIONAL LICENSE#:

Knowledge and Skill Areas

TRAINING ACTIVITY	DATE	LOCATION	TRAINING PROVIDER AS DEFINED BY RULE	HOURS
PROFESSIONAL AND ETHICAL ISSUES				
FOUNDATIONAL KNOWLEDGE OF BEHAVIORAL CHANGE PRINCIPLES				
ASSESSMENT				
IMPLEMENTATION OF PRESCRIBED INTERVENTION PLANS				
DATA COLLECTION AND DOCUMENTATION				
The cumulative duration of the training must total at least 40 hours for the knowledge and skill areas listed above.			**Total hours =**	

By signing below, I verify that the listed 40 hours of professional training in applied behavior analysis was completed by the above named applicant.

Signature of individual providing verification: **Date:**

Return All Pages Of This Application And Keep A Copy For Your Records

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INTERVENTIONIST ABA KNOWLEDGE AND SKILLS LIST

Task	Description
I. Professional and Ethical Issues	
I-1	Abide by employer, state & federal regulations regarding procedures for storing, transporting and sharing confidential electronic or paper documents or files with client identifying information
I-2	Abide by employer, state & federal reporting regulations (e.g., mandatory reporting laws)
I-3	Describe the role of the registered interventionist based on BARB requirements
I-4	Communicate with colleagues, caregivers, other stakeholders as indicated by supervisor
I-5	Demonstrate professional behavior in family homes, schools, community environments
I-6	Recognize and prevent perceived or actual conflicts of interest or dual relationships
I-7	Recognize situations requiring additional supervision and request in appropriate timeframe
I-8	Identify characteristics of populations served (e.g., autism, intellectual disability, etc.)
I-9	Understand and protect rights of consumers (e.g., using evidence-based practices, right to effective treatment, applicable state/federal laws)
I-10	Accept (and apply) performance feedback on maintenance or improvement of skills
II. Foundational Knowledge of Behavioral Change Principles	
II-1	Define Applied Behavior Analysis (ABA)
II-2	Define behavior & provide operational definitions
II-3	Demonstrate stimulus control transfer procedures
II-4	Discuss functions of behavior (e.g., socially mediated, automatic)
III. Assessment	
III-1	Contribute to standardized or curriculum-based language, play, academic, or adaptive behavior assessment as trained and indicated by supervisor
III-2	Contribute to functional behavior assessment (indirect vs. direct methods; collect ABC data, functional analysis etc.)
III-3	Implement systematic preference assessments to identify potential reinforcers
IV. Implementation of Prescribed Intervention Plans	
IV-1	Continuous & intermittent schedules of reinforcement
IV-2	Antecedent-based interventions (motivating operations, choice etc.)
IV-3	Differential reinforcement procedures
IV-4	Extinction procedures
IV-5	Positive and negative punishment procedures
IV-6	Procedures that address generalization and maintenance
IV-7	Prompts and use prompting hierarchies
IV-8	Prompt fading
IV-9	Error correction procedures
IV-10	Discrete trial teaching procedures
IV-11	Task analyses (chaining)
IV-12	Shaping procedures
IV-13	Naturalistic teaching strategies (e.g., incidental teaching)
IV-14	Assisting with caregiver/stakeholder training as authorized by supervisor
IV-15	Prescribed crisis or emergency management procedures
V. Data Collection and Documentation	
V-1	Prepare for session (data collection, materials)
V-2	Collect data using continuous recording methods (frequency, duration, latency, IRT)
V-3	Collect data using discontinuous recording methods (e.g., interval recording procedures)
V-4	Collect data using permanent products methods
V-5	Graph collected data
V-6	Write objective and specific session notes (e.g., mastery of skills, difficulties, illness, etc.)
V-7	Communicate with supervisor

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BEHAVIOR ANALYSIS INTERVENTIONIST OVERSIGHT LOG

This form identifies the oversight of the Behavior Analysis Interventionist as provided by the supervising Behavior Analyst, Assistant Behavior Analyst, or Licensed Health Care Professional. As outlined in OAR 824-040-0010(6), the registered interventionist must maintain this log, and all other training and supervision records, for a period of five years after the last day of training and supervision, and upon request, the interventionist must make such records available for inspection by the Office.

1. Interventionist Information

INTERVENTIONIST'S NAME: LAST	FIRST	MIDDLE INTIAL	BARB REGISTRATION #

2. Supervisor Information

SUPERVISOR'S NAME: LAST	FIRST	MIDDLE INTIAL	BARB REGISTRATION #

3. Log

DATE INTERVENTIONIST'S DIRECT SERVICE HOURS BEGAN

The supervisor must provide a combination of direct and indirect supervision of each interventionist for **at least 5 percent** of that interventionist's service hours; and

The supervisor must provide direct supervision **at least once per calendar month in the months when services were provided**.

Entries:

Date of entry:

Total hours since last entry:	Total **ongoing** oversight hours provided:	% of ongoing oversight:	Total **direct** supervision hours provided:	% of direct supervision:

Notes:

Date of entry:

Total hours since last entry:	Total **ongoing** oversight hours provided:	% of ongoing oversight:	Total **direct** supervision hours provided:	% of direct supervision:

Notes:

A Copy Of This Oversight Log Must Be Maintained By The Supervisor For At Least 5 Years

Behavior Analysis Interventionist Oversight Log (continued)

Interventionist

INTERVENTIONIST'S NAME: LAST	FIRST	MIDDLE INTIAL

Entries:

Date of entry:

Total hours since last entry:	Total **ongoing** oversight hours provided:	% of ongoing oversight:	Total **direct** supervision hours provided:	% of direct supervision:

Notes:

Date of entry:

Total hours since last entry:	Total **ongoing** oversight hours provided:	% of ongoing oversight:	Total **direct** supervision hours provided:	% of direct supervision:

Notes:

Date of entry:

Total hours since last entry:	Total **ongoing** oversight hours provided:	% of ongoing oversight:	Total **direct** supervision hours provided:	% of direct supervision:

Notes:

Date of entry:

Total hours since last entry:	Total **ongoing** oversight hours provided:	% of ongoing oversight:	Total **direct** supervision hours provided:	% of direct supervision:

Notes:

A Copy Of This Oversight Log Must Be Maintained By The Supervisor For At Least 5 Years

Oregon Health Authority
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CRIMINAL RECORDS CHECK FINGERPRINT PROCESS

Information

Pursuant to Oregon Revised Statute 676.612(3), the Health Licensing Office (HLO) may require a fingerprint criminal records check on persons applying for authorization to practice, renewing an authorization, or who are under investigation by the Office for practice in a profession or occupation listed in Oregon Revised Statutes (ORS) 676.583. The criminal background check is conducted through the Oregon State Police (OSP). The Livescan electronic fingerprinting process is provided by Fieldprint Inc.

Clarification

Livescan is the process by which an applicant is electronically fingerprinted.

Fieldprint Inc is the company that the State of Oregon has contracted with to conduct the Livescan electronic fingerprinting.

Because the State of Oregon has contracted with Fieldprint Inc. to conduct the Livescan electronic fingerprinting, the HLO is required to have all applicants who are subject to a criminal background check use a Fieldprint office to process the Livescan fingerprints.

Instructions

1. The HLO only accepts Livescan fingerprinting electronically submitted to OSP by **Fieldprint Inc.**

2. To locate a Fieldprint office in the state of Oregon, visit: www.fieldprintoregon.com. For Fieldprint locations in another state, visit: www.fieldprint.com, click on “Make an Appointment” in the menu bar at the top of the page, scroll down to “State Government” and choose a state. If your state is not listed there, scroll to the bottom of the page to “Find a Location” and enter your city or zip code.

3. To schedule an appointment with a Fieldprint office, you will first register as a user of the Fieldprint system. Once you are registered, you will be prompted to enter the HLO Fieldprint code to be properly routed. **Enter Fieldprint Code: FPORHealthLicDAS**.

4. Once your fingerprint process is complete, your criminal background check will be available to the HLO during the processing of your application for authorization to practice.

For questions regarding the fingerprinting processes, please visit Fieldprint’s website at: www.fieldprint.com, or contact Fieldprint customer service at: (877) 614-4364 or via email at: CustomerService@fieldprint.com.

For questions regarding the processing of your application for authorization to practice, you may visit the HLO website at www.healthoregon.org/hlo or contact the Office at the address, phone, or email listed above.