OREGON HEALTH AUTHORITY

Hemodialysis Technician

HCRQI Office Use Only

FEE_____

HRS_____

CEU's_____

LATE FEE_____

Application for Certification

If you need this document in an alternate format, please contact
Health Care Regulation and Quality Improvement
Phone: 971-673-0540 Fax: 971-673-0556
Applications must be submitted via mail,
NO WALK IN'S

Documentation and Fee Must Accompany This Application

Full Certification		Provisional Certification	
Initial *	☐	Initial *	☐
Renewal*	☐	Renewal*	☐
Name/Address Change	☐	Name/Address Change	☐
* Fee Payment Required (See Hemodialysis Technician Schedule & FAQ's)			

Applicant Information (Please print clearly or use PDF Option)

Name			
Last :	First:	Middle:	Maiden:
Address			
Number and Street/ Apt #:			
City:	State:	Zip:	
Telephone Phone:	Social Security Number**:		
Email:			
Dates Required			
Date of Birth:	BONENT Passed:	NNCC, NNCO, CCHT Passed:	
Please check one below – *Documentation of Completion <u>Required</u> for Initial Certifications ONLY*			
High School ☐	GED ☐		

***As part of your application for certification issued by Health Care Regulation and Quality Improvement (HCRQI), you are required to provide your Social Security Number to HCRQI. **THIS IS MANDATORY FOR ALL INITIAL CERTIFICATIONS.** The Authority for this requirement is Oregon Laws 1977, Chapter 746, Section 117 (OAR 25.785) and 42 USC 666 (a)(13)*

Hemodialysis Employers (*Required for All Certifications)*

List your Hemodialysis Employers, starting with the most recent			
Facility Name	**Location**	**Dates of Employment From - To**	
		From:	To:
		From:	To:
		From:	To:
		From:	To:

Hemodialysis Training (*Required ONLY for ALL Initial Certifications)*

Please provide documentation of the Hemodialysis training you have received. This should include classroom as well as clinical training. Attach additional pages to this application if necessary. ***Manager Signature Required***			
Date	**Title**	**Sponsor**	**Time**

I hereby certify that the above named individual and the information given is true and correct.

_____ _____

Manager Signature ***Date (mm/dd/year)***

Questions (*Required for All Certifications)*

Please answer all of the following questions. "Yes" responses require a detailed written explanation. Attach additional pages to this application with responses.	
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 ☐
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 **<u>been taken</u>** 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 a 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 laws or prescribed controlled substances for yourself? b) Committed any act involving dishonestly or corruption? c) Violated any state or federal law or rule regulating the practice of a health care profession?	 Yes ☐ No ☐ Yes ☐ No ☐ 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 state, federal or foreign authority?	Yes ☐ No ☐

Hours Worked (***Required ONLY for Certification Renewals)***

Please use the provided section to list the # of hours worked during the current certification Period*. ***** Hours worked need to be obtained during the current 2 year certification period. Example: Hours need to be obtained through years 2009-2011 for Certification Renewal Year of 2011-2013. Manager Signature Required.***
Hours Worked

I hereby certify that the above named individual and the information given is true and correct.

_____ _____

Manager Signature ***Date (mm/dd/year)***

Continuing Education (***Required ONLY for Certification Renewals)***

Please provide documentation of continuing education. This can include in-services, conference, 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 a copy of the certificate/s received upon completion. ***For additional assistance on number of CEU's required please see our Hemodialysis Technician Fee Schedule & FAQ's online***

PLEASE REVIEW YOUR APPLICATION FOR COMPLETENESS AND REQUIRED SIGNATURES

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. *In addition if submitting an initial certification issued by Health Care Regulation and Quality Improvement (HCRQI), you are required to provide your Social Security Number to HCRQI.* ***THIS IS MANDATORY FOR ALL INITIAL CERTIFICATIONS.*** *The Authority for this requirement is Oregon Laws 1977, Chapter 746, Section 117 (OAR 25.785) and 42 USC 666 (a)(13)* Health Care Regulation & Quality Improvement 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 (mm/dd/year)***

Applications must submitted via mail, NO WALK IN'S

Make check payable to Oregon Health Authority and mail to:
Health Care Regulation and Quality Improvement
P.O. Box 14260, Portland, OR 97293

HCRQI Office Use Only

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

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

Initials: _____ Date: _____

CASH OFFICE: QC **623** initial/QC **624** renewal **70320 70594**