



**HEALTH LICENSING OFFICE  
Behavior Analysis Regulatory Board**

1430 Tandem Ave. NE, Suite 180, Salem OR 97301  
Phone: 503-378-8667 | Fax: 503-370-9004  
[healthoregon.org/hlo](http://healthoregon.org/hlo) | Email: [hlo.info@state.or.us](mailto:hlo.info@state.or.us)

**ASSISTANT BEHAVIOR ANALYST LICENSE APPLICATION**

**1. Applicant Information**

APPLICANT NAME: LAST			FIRST			MIDDLE INITIAL		
RESIDENTIAL PHYSICAL ADDRESS (REQUIRED)								
CITY						STATE		ZIP
MAILING ADDRESS (IF DIFFERENT FROM RESIDENTIAL ADDRESS)								
CITY						STATE		ZIP
PHONE: <input type="checkbox"/> HOME <input type="checkbox"/> CELL			BUSINESS TELEPHONE			EMAIL		
GENDER <input type="checkbox"/> Female <input type="checkbox"/> Male			BIRTHDATE			SOCIAL SECURITY NUMBER or TAX IDENTIFICATION NUMBER (REQUIRED)		
<input checked="" type="radio"/> Have you ever been known under any other name? <input type="checkbox"/> No <input type="checkbox"/> Yes – If yes, list full name(s):								
<input checked="" type="radio"/> Current BACB Certified Assistant Behavior Analyst Certification number:								
<input checked="" type="radio"/> Do you hold or have you previously held licensure, certification or registration with the Health Licensing Office or any other state? <input type="checkbox"/> No <input type="checkbox"/> 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:		
State:		Lic./Cert./Reg.#				Expiration:		

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

**Method Of Payment For Application Fee = \$125; License Fee = \$175**

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 Certification Verified  LEDS Check Completed

**3. 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**):

<p>● Have you ever been convicted of a misdemeanor or felony? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list <b>all</b> convictions, including the charges as stated in the court documents and year convicted (<b>attach additional pages if necessary</b>).</p>	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.

<b>Applicant Signature:</b>	<b>Date:</b>
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ORS 181.534, 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.

<b>Applicant Signature:</b>	<b>Date:</b>
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4. SUPERVISOR INFORMATION		
SUPERVISOR NAME: LAST	FIRST	MIDDLE INITIAL
Supervisor holds a license in Oregon as a Behavior Analyst with the Behavior Analysis Regulatory Board (BARB): License # _____ Expiration Date: _____		
PRIMARY PHYSICAL ADDRESS WHERE SUPERVISION WILL TAKE PLACE (REQUIRED)		
CITY	STATE	ZIP
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.
<b>Ethnic Background</b> ( <i>check only one</i> )
<input type="checkbox"/> (A) <b>Asian or Pacific Islander:</b> 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.
<input type="checkbox"/> (B) <b>African American</b> ( <i>not of Hispanic origin</i> ): Persons having origins in any of the Black racial groups of Africa.
<input type="checkbox"/> (H) <b>Hispanic:</b> Persons of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish cultures or origin, regardless of race.
<input type="checkbox"/> (I) <b>American Indian or Alaskan Native:</b> Persons having origins in any of the original peoples of North America, and who maintain cultural identification through tribal affiliation or community recognition.
<input type="checkbox"/> (W) <b>Caucasian</b> ( <i>not of Hispanic origin</i> ): Persons having origins in any of the original peoples of Europe, North Africa or the Middle East.

<b><u>REQUIREMENTS FOR ASSISTANT BEHAVIOR ANALYST LICENSE APPLICATION</u></b>
<input type="checkbox"/> 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 = <b>\$125</b> ( <i>see method of payment section above</i> );
<input type="checkbox"/> Submit one form of acceptable <b>photographic</b> identification as outlined in OAR 331-030-0000(10), <b>which must include applicant's current legal name:</b> Front and back of legible (clear) photocopies if submitted by mail; <i>driver license, state ID card, passport or military ID card</i> ;
<input type="checkbox"/> Arrange for proof of current certification by the Behavior Analyst Certification Board, Incorporated, as a Board Certified Assistant Behavior Analyst to be sent from the BACB to the Office;
<input type="checkbox"/> Pass a fingerprint-based nationwide criminal records check pursuant to OAR 331-030-0004;
<input type="checkbox"/> Be supervised by a Behavior Analyst who is licensed by the Behavior Analysis Regulatory Board (BARB);
<input type="checkbox"/> If applicable, submit an affidavit of licensure from any state where the individual holds or has held a license as an assistant behavior analyst whether the license is active or inactive; and
<input type="checkbox"/> Submit required license fee = <b>\$175</b> ( <i>see method of payment section above</i> ).