CLANDESTINE DRUG LAB PROGRAM
TRAINING REGISTRATION
AND LICENSE APPLICATION FORM

Oregon Health Authority

BUSINESS NAME: ______________________

STREET ADDRESS: ______________________

CITY/STATE/ZIP: ______________________

MAILING ADDRESS: (if different): __________________

OWNER OR PRINCIPAL NAME: __________________ PHONE: _________________

CCB GENERAL CONTRACTOR LICENSE # (ENCLOSE COPY): __________________

EMPLOYEE INFORMATION (Please attach a continuation sheet, if necessary):

NAME/TITLE **(must indicate Worker or Supervisor)** *** see note on providing SSN**	**HAZMAT TRAINING – per 29CFR 1910.120(e)**	**DATE**
Name:______________________ SSN:______________________ ☐ Worker ☐ Supervisor	• Initial: (40 hr.) Course: • Refresher Course (most recent): • Supervisor (8 hr.) Course – if applicable:	___/___/_____ ___/___/_____ ___/___/_____
Name: ______________________ SSN:______________________ ☐ Worker ☐ Supervisor	• Initial: (40 hr.) Course: • Refresher Course (most recent): • Supervisor (8 hr.) Course – if applicable:	___/___/_____ ___/___/_____ ___/___/_____
Name: ______________________ SSN:______________________ ☐ Worker ☐ Supervisor	• Initial: (40 hr.) Course: • Refresher Course (most recent): • Supervisor (8 hr.) Course – if applicable:	___/___/_____ ___/___/_____ ___/___/_____
Name: ______________________ SSN:______________________ ☐ Worker ☐ Supervisor	• Initial: (40 hr.) Course: • Refresher Course (most recent): • Supervisor (8 hr.) Course – if applicable:	___/___/_____ ___/___/_____ ___/___/_____

OVER

I declare under penalty of perjury and the provisions of ORS 453.888 that I have examined this application and all attachments, and to the best of my knowledge and belief the enclosed information is true, correct, and complete. I will notify the Oregon Health Authority of any changes in this information within 30 days of any such change.

SIGNATURE (Owner or Principal) DATE

NAME (please print)

Please check the appropriate box(es) below, enclose the total dollar amount in the form of a check or money order payable to the STATE OF OREGON, and send it to: Oregon Health Authority, Business Services, PO Box 14260, Portland, OR 97293-0450.

	FEE DESCRIPTION	INDEX	PCA	OBJECT	AMOUNT	NUMBER OF ATTENDEES	TOTAL
☐	License (even year)	50207	51303	2220	$ 1,000.00		$ 0.00
☐	License (odd year)	50207	51303	2220	$ 500.00		$ 0.00
☐	Registration per Person	50207	51303	2381	$ 150.00		$ 0.00
☐	Exam Fee per Person	50207	51303	2205	$ 100.00		$ 0.00
						FINAL TOTAL	$ 0.00

Licenses expire June 30 of even-numbered years.

PLEASE NOTE:

Under OAR 333-040-0180(5), no portion of the above fees is refundable unless submitted in error and the application is withdrawn by written request on the applicant within 10 working days of submission.

*** Social Security Numbers Required on Permit Applications**

As part of your application for an initial or renewed Drug Lab Decontamination Contractor License issued by the Oregon Health Authority, you are required to provide your Social Security Number. This is mandatory. The authority for this requirement is **Oregon Laws 1997, Chapter 746, Section 117 (ORS 25.785) and 42 USC § 666 (a) (13**). Failure to provide your Social Security Number will be a basis to refuse to issue or renew the permit you seek. Although a number other than your Social Security Number appears on the face of the permit issued by the Oregon Health Authority, your Social Security Number will be used for child support enforcement purposes only, unless you authorize other uses of the number.