HEALTH LICENSING OFFICE
Behavior Analysis Regulatory Board
1430 Tandem Ave. NE, Suite 180, Salem, OR 97301-2192
Phone: (503) 378-8667 | Email: hlo.info@odhsoha.oregon.gov
Web: www.oregon.gov/oha/ph/hlo

For Office Use Only		
Applicant #:	License #:	Staff Initials:

Behavior Analysis Interventionist Registration Application

Applicant Information

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
BIRTHDATE:	GENDER: ☐ FEMALE ☐ MALE	☐ NONBINARY / OTHER
RESIDENTIAL PHYSICAL ADDRESS (**REQUIRED**):		
CITY:	STATE:	ZIP:
MAILING ADDRESS (IF DIFFERENT FROM ABOVE):		
CITY:	STATE:	ZIP:
BUSINESS PHONE:	PERSONAL PHONE:	
EMAIL (**REQUIRED**):	SOCIAL SECURITY # (**REQUIRED**):	

Have you ever been known under any other legal name? ☐ **No** ☐ **Yes**
If yes, list all previous full (legal) names:

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 (add additional blank page if necessary):

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

Payment Information (complete this section only if submitting payment by mail)

Required Fees: (*The application fee is non-refundable)

***Application Fee = $75**	**License Fee = $100**	**Total of $175**

Please check one: ☐ Credit Card (see below) ☐ Check ☐ Money Order ☐ Purchase Order **DO NOT MAIL CASH**

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 (send by way of postal mail).**

Name on card: ____

Card number: ______________________________ Exp: ____________ Authorized amount: $__________

Cardholder signature: ____

(Do not write in the following section – Official use only)

Method of Payment: ☐ Visa ☐ MasterCard ☐ Discover ☐ Cash ☐ Check ☐ MO ☐ PO AMOUNT: ______________ INITIALS: ______________ ☐ APPROVAL CODE/CK#: ____________	Method of Payment: ☐ Visa ☐ MasterCard ☐ Discover ☐ Cash ☐ Check ☐ MO ☐ PO AMOUNT: ______________ INITIALS: ______________ ☐ APPROVAL CODE/CK#: ____________	Method of Payment: ☐ Visa ☐ MasterCard ☐ Discover ☐ Cash ☐ Check ☐ MO ☐ PO AMOUNT: ______________ INITIALS: ______________ ☐ APPROVAL CODE/CK#: ____________

Individual Records Questions

Please accurately answer all the questions below. The Health Licensing Office (HLO) 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.

1. Do you have any pending or completed investigations or any disciplinary actions taken against you by any licensing or regulatory authority? 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, attach an additional page(s) and provide an explanation.

2. Have you ever been convicted of a misdemeanor or felony? ☐ **Yes** ☐ **No** If yes, please list all convictions, including the charges and year convicted (attach additional pages if necessary).	**Year Convicted**

3. 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.

Mandatory Social Security Number Disclosure and Use

You are required to provide your Social Security number (SSN) to the HLO as part of your application for initial or renewed occupational or professional license, certification, or registration issued by HLO pursuant to ORS 25.785, ORS 305.385, 42 USC § 666(a)(13) and 42 USC §405(c)(2)(C)(i). Failure to provide your SSN will be a basis to refuse to issue or renew the license, certification, or registration you seek. HLO is authorized by law to use your SSN for child support enforcement and tax administration purposes only. HLO will only use your SSN for these purposes unless you authorize other uses of your SSN as discussed below. Your SSN will remain on file with HLO. If you have never been assigned an SSN, please refer to the section below titled Request for Exemption from Social Security Number Disclosure and Attestation.

Voluntary SSN Disclosure and Use - Criminal Background Checks and Military Status Verification

The HLO is authorized to conduct criminal background checks pursuant to ORS 181A.195, 676.608, and 676.612. The HLO requests that you voluntarily provide your SSN for this purpose. Pursuant to 50 USC § 3931, the HLO must determine the military status (or lack thereof) of a respondent before issuing a default final order. The HLO requests that you voluntarily provide your SSN for this purpose. Failure to provide your SSN for these purposes will not be used to deny your application, or to deny you any right, benefit or privilege provided by law. If you consent to the use of your SSN by the HLO for these purposes, it may be used only for these purposes.

4. I voluntarily consent to disclose my SSN to the HLO for criminal background checks and military status verification.
   ☐ **Yes** ☐ **No**

Voluntary Social Security Number Disclosure and Use – Reporting to the National Practitioner Data Bank (NPDB)

For any HLO license, certification, or registration that reports to the National Practitioner Data Bank (NPDB), if any disciplinary action is taken against you, HLO requests that you voluntarily provide your SSN so that HLO may report it to the NPDB under Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986; Section 1921 of the Social Security Act; Section 1128E of the Social Security Act; and their implementing regulations found at 45 CFR Part 60. Failure to provide your SSN for this purpose will not be used to deny your application, or to deny you any right, benefit or privilege provided by law. If you consent to the use of your SSN by the HLO for this purpose, it may be used only for this purpose.

5. I voluntarily consent to disclose my SSN to the HLO to report to the NPDB. ☐ **Yes** ☐ **No**

Request for Exemption from Social Security Number Disclosure and Attestation

6. If you do not have a Social Security number (SSN) you may request an exemption from the SSN requirement. To receive the exemption, you must attest and certify that you have never been assigned an SSN and if you are ever assigned an SSN, you will report it to the HLO within 30 days.

   DO NOT SIGN BELOW IF YOU HAVE A SOCIAL SECURITY NUMBER

   By signing below, I attest and certify that I have never been assigned an SSN and agree that if an SSN is assigned to me, I will report it to the HLO within 30 days.

Applicant Signature:	Date:

Certification of Information Provided

7. I have examined this application and supporting documentation and certify by my signature below that it is true, correct, and complete. I understand that providing false information or 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:

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Affirmative Action – Voluntary Question

The State of Oregon has an Affirmative Action (AA) Policy. If you choose to provide the optional information below, it will help to evaluate the effectiveness of our AA 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.

Which of the following describes your racial or ethnic identity? Please check all that apply.

American Indian and Alaska Native

______ American Indian
______ Alaska Native
______ Canadian Inuit / Metis / First Nation
______ Indigenous Mexican / Central American / South America

Asian

______ Asian Indian
______ Cambodian
______ Chinese
______ Communities of Myanmar
______ Filipino / Filipina
______ Hmong
______ Japanese
______ Korean
______ Laotian
______ South Asian
______ Vietnamese
______ Other Asian

Black and African American

______ African American
______ Afro-Caribbean
______ Ethiopian
______ Somali
______ Other African (Black)
______ Other Black

Hispanic and Latino/Latina/Latinx

______ Central American
______ Mexican
______ South American
______ Other Hispanic or Latino/Latina/Latinx

Middle Eastern / North African

______ Middle Eastern
______ North African

Native Hawaiian and Pacific Islander

______ Chamoru/Chamorro
______ Guamanian
______ Marshallese / Micronesian / Palauan / Tongan
______ Communities of the Micronesian Region
______ Native Hawaiian
______ Samoan
______ Other Pacific Islander

White

______ Eastern European
______ Slavic
______ Western European
______ Other White

Other Categories

______ Other: ________________________
______ Unknown
______ Decline to answer

If you checked more than one race or ethnicity above, is there **one** you think of as your primary racial or ethnic identity?

______ Yes, please list: ______________________________
______ I do not have just one primary racial or ethnic identity
______ No, I identify as Bi-racial or Multi-racial
______ Not applicable, I only checked one category above
______ Unknown
______ Decline to answer

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Application Requirements

PLEASE NOTE: The applicant is responsible for payment of fees assessed by the issuing organization(s) when obtaining required official documentation.

Applicant must:

______	Meet the requirements of Oregon Administrative Rule, Chapter 331, Division 30.
______	Submit this completed application accompanied by payment of required fees: *Application fee = **$75**; and License fee = **$100**; for a total of **$175** (see payment section on first page). ***DO NOT SEND CASH THROUGH THE MAIL.*** ****THE APPLICATION FEE IS NON-REFUNDABLE.***
______	Submit **two** forms of original identification issued by a government agency. Acceptable identification options can be found under Chapter 331, Division 30 of Oregon Administrative Rule. **ID requirements are as follows:** • The two forms of ID must be issued by a government agency. • Both the ID's must include the applicant's current legal name. • At least one form of ID provided must be photographic. • We do not accept student ID cards, Costco cards, debit cards, etc. If you have a question about whether a particular ID type is acceptable, please call (503) 378-8667, to verify. • If submitting photocopies of your ID by mail, legible (clear) front and back copies must be submitted. Submit the copies on a full-sized piece(s) of copy paper, do not cut the ID images out. If you do not meet all of ID requirements above, you run the risk of your application process being delayed.
______	Submit proof of being at least 18 years of age and provide official documentation confirming date of birth, such as a copy of the birth certificate, driver's license, passport, or school/military/governmental record with age documented (if not already provided on photographic identification required above).
______	Submit proof of having a high school diploma or equivalent, or a degree from a post-secondary institution.
______	Submit documentation of 40 hours of professional training in applied behavior analysis on the "Interventionist Verification of Professional Training" form (see form attached) in the following knowledge and skill areas, as verified by an individual listed in Oregon Revised Statutes 676.802(2)(a-h) or licensed by the Board: • Professional and ethical issues; • Foundational knowledge of behavioral change principles; • Assessment; • Implementation of prescribed intervention plans; • Data collection and documentation.
______	Submit a fingerprint-based national criminal background check (see criminal records check fingerprint process instructions attached).

Oregon Health Authority

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Interventionist ABA Knowledge and Skills List

I. Professional and Ethical Issues

Task	Description
I-1	Abide by employer, state and 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 and federal reporting regulations (i.e., 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 (i.e., autism, intellectual disability)
I-9	Understand and protect rights of consumers (i.e., 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

Task	Description
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 (i.e., socially mediated, automatic)

III. Assessment

Task	Description
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 (i.e., indirect vs. direct methods; collect ABC data, functional analysis)
III-3	Implement systematic preference assessments to identify potential reinforcers

IV. Implementation of Prescribed Intervention Plans

Task	Description
IV-1	Continuous & intermittent schedules of reinforcement
IV-2	Antecedent-based interventions (i.e., 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)

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Interventionist ABA Knowledge and Skills List (continued)

IV. Implementation of Prescribed Intervention Plans (continued)	
Task	**Description**
IV-12	Shaping procedures
IV-13	Naturalistic teaching strategies (i.e., 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	
Task	**Description**
V-1	Prepare for session (i.e., data collection, materials)
V-2	Collect data using continuous recording methods (i.e., frequency, duration, latency, IRT)
V-3	Collect data using discontinuous recording methods (i.e., interval recording procedures)
V-4	Collect data using permanent products methods
V-5	Graph collected data
V-6	Write objective and specific session notes (i.e., mastery of skills, difficulties, illness)
V-7	Communicate with supervisor

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Interventionist Verification of Professional Training

Pursuant to Oregon Administrative Rule, **40 hours** of professional training in applied behavior analysis must be verified by an individual listed in statute or licensed by the Board.

Applicant Information

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:

Verifying Individual's Information

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:

Verifying Individual's Licensure Credential *(select or mark one of the two options below)*

______	Behavior Analyst or Assistant Behavior Analyst licensed with the Behavior Analysis Regulatory Board (BARB)
BARB License #:	
or…	
______	Licensed Health Care Professional as listed in Oregon Revised Statute
Health Care Professional License #:	

Knowledge and Skills Area

Training Activity:	Training Provider as Defined by Rule:	Location:	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 =**	

Training Completion Date

Provide the date the 40 hours of professional training was completed:

Verification Acknowledgement

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

Signature:	**Date:**

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Interventionist Supervision Agreement (page 1 of 2)

This form identifies the responsibilities of the Behavior Analysis Interventionist and the supervising Licensed Behavior Analyst, Licensed Assistant Behavior Analyst, or a 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 Behavior Analysis Interventionist for a period of at least five years after the last day of training and supervision.

Interventionist Information

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:

Supervisor Information

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:

Supervisor's Licensure Credential *(select or mark one of the two options below)*

______	Behavior Analyst or Assistant Behavior Analyst licensed with the Behavior Analysis Regulatory Board (BARB)
BARB License #:	

or…

______	Licensed Health Care Professional as listed in Oregon Revised Statute
Health Care Professional License #:	

Supervisor's Employment Information

EMPLOYER:

EMPLOYER PHYSICAL ADDRESS:

CITY:	STATE:	ZIP:

Location of Supervision

☐ Supervisor's Office ☐ Interventionist's Office ☐ Other (explain): _____

NAME OF FACILITY WHERE SUPERVISION WILL TAKE PLACE:

FACILITY PHYSICAL ADDRESS:

CITY:	STATE:	ZIP:

Interventionist Supervision Agreement (page 2 of 2)

This form identifies the responsibilities of the Behavior Analysis Interventionist and the supervising Licensed Behavior Analyst, Licensed Assistant Behavior Analyst, or a 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 Behavior Analysis Interventionist for a period of at least five years after the last day of training and supervision.

Interventionist 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 (HLO), 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 HLO website, or on the supervisor's form that contains all the same information.
- I will notify the HLO 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 rule, and understand that failure to comply with these standards may constitute unprofessional conduct which is subject to discipline under Oregon Revised Statute.
- 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.
- I will maintain all training and supervision records for a minimum of five years after the last day of training and supervision and must make records available for inspection by the HLO.

Interventionist Acknowledgement

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

Interventionist Signature:	**Date:**

Supervisor Responsibilities

Supervising Behavior Analyst, Assistant Behavior Analyst, or 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 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.
- I will evaluate the interventionist subject to this agreement at least once a year after initial competency assessment on the form available on the HLO website or on another evaluation form with the same information.

Supervisor Acknowledgement

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

Supervisor Signature:	**Date:**

Oregon Health Authority

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Criminal Records Check

Please note: You must submit a profession specific application (this application) to the Health Licensing Office (or have it postmarked) within 30 days of having your fingerprints taken. If you do not submit your application within 30 days, you will be required to have your fingerprints taken again before your application can be processed.

Pursuant to Oregon Revised Statute (ORS) 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 HLO for practice in a profession or occupation listed in ORS 676.565. 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.

Fingerprint Process Instructions

Please take the following steps to have your fingerprints taken:

Note: The HLO only accepts Livescan fingerprinting electronically submitted to OSP by Fieldprint Inc.

1. 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 down to the bottom of the page to “Find a Location” and enter your city zip code.
2. To schedule an appointment with a Fieldprint office, you must 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
3. Remember to submit your profession specific application to the HLO (or have it postmarked) within 30 days of having your fingerprints taken. If not, you will be required to have your fingerprints taken again before your application can be processed.
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 process, 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.oregon.gov/oha/ph/hlo or contact the Office at the address, phone, or email listed above.

Please note: You must submit a profession specific application (this application) to the Health Licensing Office (or have it postmarked) within 30 days of having your fingerprints taken. If you do not submit your application within 30 days, you will be required to have your fingerprints taken again before your application can be processed.