



HEALTH LICENSING OFFICE
Board of Cosmetology

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 #: Facility Applicant #:
Certification #: Staff Initials:

Cosmetology Facility License Application

Applicant Information (Responsible Party) The holder of a facility license must be a natural person.

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

Facility Information (As Filed with the Secretary of State, Corporation Division)

FACILITY NAME: BUSINESS PHONE:
ASSUMED BUSINESS NAME: REGISTRY NUMBER:
FACILITY PHYSICAL ADDRESS:
CITY: STATE: ZIP:
FACILITY MAILING ADDRESS (IF DIFFERENT FROM ABOVE):
CITY: STATE: ZIP:
Are you closing a previous facility? No Yes If yes, list your facility license number: COS-FA-
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)

\*Facility Application Fee = \$140 Facility License Fee = \$155 Total of \$295

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 - Office use only)

OTC Verified ID Verified Out-of-state Licensure Type of ID: \_\_\_\_\_ Appr Code/CK # \_\_\_\_\_ Staff Initials \_\_\_\_\_

### 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

### Request for Exemption from Social Security Number Disclosure and Attestation

5. 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

6. 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:**

## Cosmetology Facility License Application (continued)

### Additional Facility Owners / Partners Information

In addition to the applicant (responsible party) listed on page one of this application, list all the name(s) of any other natural persons who are additional owners/partners of the facility for which this application is being submitted. Attach additional pages if necessary. **Note:** Additional owners must sign, or the information will not be updated in the Health Licensing Office database.

Facility owners listed below who hold a practitioner certification are not required to obtain an independent contractor's license to practice in this facility since they are an owner of the facility.

Printed Name:	Practitioner Certification # (if applicable)	Signature:

### Employee Information

List all the names(s) and practitioner certificate number(s) of authorization holders who are currently an **“employee”** of the facility for which this application is being submitted. Attach additional pages if necessary. **Note:** Employees must sign, or the information will not be updated in the Health Licensing Office database.

Printed Name:	Practitioner Certification #	Signature:

### Independent Contractor Information

List all the names(s) and registration number(s) of authorization holders who currently lease a station in your facility and hold an **“independent contractor”** registration. Attach additional pages if necessary. **Note:** Independent contractors must sign, or the information will not be updated in the Health Licensing Office database.

Printed Name:	IC Registration #	Signature:

**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

## 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, <a href="#">Chapter 331, Division 30</a> .
_____	Submit this completed application, accompanied by payment of the required fees. *Facility Application fee = <b>\$140</b> ; and Facility License fee = <b>\$155</b> ; for a total of <b>\$295</b> (see payment information on first page). <b>DO NOT SEND CASH THROUGH THE MAIL.</b> <b>*THE APPLICATION FEE IS NON-REFUNDABLE.</b>
_____	Submit <b>one</b> form of original identification issued by a government agency. Acceptable identification options can be found under <a href="#">Chapter 331, Division 30</a> of Oregon Administrative Rule. <b>ID requirements are as follows:</b> <ul style="list-style-type: none"> <li>• The ID must be issued by a government agency.</li> <li>• The ID must include the applicant's current legal name.</li> <li>• The ID provided must be photographic.</li> <li>• We do not accept student ID cards, department store or warehouse cards, debit cards, etc. If you have a question about whether a particular ID type is acceptable, please call (503) 378-8667, to verify.</li> <li>• If submitting a photocopy of your ID by mail, a legible (clear) front and back copy must be submitted. Submit the copy on a full-sized piece(s) of copy paper, do not cut the ID images out.</li> </ul> If you do not meet all of the 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 a map or directions to the facility if it is located in a rural or isolated area.
_____	Have you provided the facility name on page one of this application?
_____	Have you provided a list of ALL owners, partners, employees, and independent contractors with this application?
_____	Have you answered questions 1 through 4 on page two of this application? If you fail to answer each of the four questions, this form will be returned to you and potentially cause a delay in the processing of the Authorization Application.
_____	If you <u>do not</u> have a social security number, have you signed and dated in section 5 on page two of this form? If you <u>do</u> have a social security number that you have provided on page one of this form, do not sign.
_____	Have you signed and dated section 6 on page two of this form? If you fail to sign and date this section, your form will be returned to you and will cause a delay in qualifying the temporary staffing agency for an authorization.

## Additional Information

**Note:**

- Please refer to the Board of Cosmetology's Oregon Administrative Rules to ensure you are meeting all the requirements of obtaining a facility license when operating a business establishment and providing services in one or more fields of practice.
- If the facility is not operating under the real and true name of each owner, the applicant must provide appropriate documentation of being registered with the Secretary of State under Oregon Revised Statute including, but not limited to, a facility operating under a corporation, limited liability corporation or an assumed business name (ABN).
- An ABN filing is not required if the business name includes the real and true name of each owner. Refer to Secretary of State, Corporations Division under Oregon Revised Statute.