



HEALTH LICENSING OFFICE  
Board of Cosmetology

1430 Tandem Ave. NE, Suite 180, Salem, OR 97301-2192  
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)

**COSMETOLOGY FACILITY LICENSE APPLICATION**

The holder of a Facility license must be a natural person.

**1. Applicant Information**

Applicant (Responsible Party) Name:	Date of Birth	Social Security Number (REQUIRED)
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Residential Physical Address (REQUIRED)

City	State	Zip
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Home Phone:	Cell Phone	Email Address
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Name of Facility	Business Telephone
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Assumed Business Name (As filed with Secretary of State, Corporation Division)	Registry Number (Secretary of State, Corporation Division)
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Facility Physical Address

City	State	Zip
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Facility Mailing Address (if different from above)

City	State	Zip
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Are you closing a previous facility?  Yes  No If yes, list your facility license number: 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.

State:	Lic./Cert./Reg.#	Expiration:
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State:	Lic./Cert./Reg.#	Expiration:
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State:	Lic./Cert./Reg.#	Expiration:
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State:	Lic./Cert./Reg.#	Expiration:
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Do you practice at this facility?  Yes  No

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

**Payment of Required Fees: Facility Application = \$140; Facility License = \$155; Total = \$295**

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)

Facility License #: COS-FA- Initials \_\_\_\_\_ OTC  Verified ID  Type: \_\_\_\_\_

Approval Code/CK# \_\_\_\_\_



**4. 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"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> 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>Signature:</b>	<b>Date:</b>
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ORS 181.534, 670.280, 676.608, 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 National Practitioner 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 National Practitioner Data Bank (NPDB). 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>Signature:</b>	<b>Date:</b>
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## 5. Race / Ethnicity – Voluntary Question

The State of Oregon has an Affirmative Action policy. If you choose to provide your race/ethnicity information below, 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 eligibility or qualifications.

### Ethnic Background (check only one)

- American Indian or Alaska Native (I)** (Non-Hispanic or Latino): A person having origins in any of the original peoples of North and South American (including central America), and who maintain a tribal affiliation or community attachment.
- Asian (A)** (Non-Hispanic or Latino): A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.
- Black or African American (B)** (Non-Hispanic or Latino): A person having origins in any of the black racial groups of Africa.
- Hispanic or Latino (H)**: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish Culture or origin regardless of race.
- Native Hawaiian or other Pacific Islander (P)** (Non-Hispanic or Latino): A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- White (W)** (Non-Hispanic or Latino): All persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.
- Two or more races (T)** (Non-Hispanic or Latino): Persons who identify with two or more racial categories named above.

### FACILITY LICENSE

Please refer to the Board of Cosmetology's Oregon Administrative Rules, Chapter 817, 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.

## **APPLICATION REQUIREMENTS FOR A COSMETOLOGY FACILITY LICENSE**

To be issued a facility license the 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 = \$140 and License fee = \$155 for a total of \$295 (see payment section above);**
- Submit **one** form of original **photographic** identification issued by a government agency, **which must include applicant's current legal name**. Front and back of legible (clear) photocopies if submitted by mail. Acceptable photographic identification options can be found under Chapter 331, Division 30 of Oregon Administrative Rule;
- 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;
- Submit on the application form, a list of authorization holders (employees and Independent Contractors) providing services in the facility;
- Submit on the application form, the name of the facility; and
- 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).

**NOTE:** ABN is not required if business includes the real and true name of each owner. Refer to Secretary of State, Corporations Division under Oregon Revised Statute.