



HEALTH LICENSING OFFICE

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

Phone: 503-378-8667 | Fax: 503-370-9004

www.healthoregon.org/hlo Email: hlo.info@state.or.us

AFFIDAVIT OF LICENSURE REQUEST

- I am currently licensed in Oregon; please send verification of my license to another state. **(*Two forms of ID REQUIRED)**
- I am moving to Oregon; please verify my license from another state. **(*Two forms of ID REQUIRED)**

SOCIAL SECURITY NUMBER	DATE OF BIRTH
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NAME: LAST	FIRST	MIDDLE INITIAL
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RESIDENTIAL PHYSICAL ADDRESS (Required)

CITY	STATE	ZIP
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MAILING ADDRESS (IF DIFFERENT FROM PHYSICAL ADDRESS)

CITY	STATE	ZIP
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PHONE: <input type="checkbox"/> HOME <input type="checkbox"/> CELL	BUSINESS PHONE	EMAIL
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PROFESSION:

<input type="checkbox"/> ATHLETIC TRAINER	<input type="checkbox"/> CERTIFIED ADVANCED ESTHETICIAN	<input type="checkbox"/> DENTURIST	<input type="checkbox"/> LONG TERM CARE
<input type="checkbox"/> BEHAVIOR ANALYSIS: <input type="checkbox"/> BEHAVIOR ANALYST <input type="checkbox"/> ASSISTANT ANALYST <input type="checkbox"/> INTERVENTIONIST	<input type="checkbox"/> COSMETOLOGY: <input type="checkbox"/> BARBER <input type="checkbox"/> ESTHETICIAN <input type="checkbox"/> HAIRDRESSER <input type="checkbox"/> NAIL TECHNICIAN	<input type="checkbox"/> DIETITIAN (NO FEE) <input type="checkbox"/> DIRECT ENTRY MIDWIFE <input type="checkbox"/> ENVIRONMENTAL HEALTH: <input type="checkbox"/> EH SPECIALIST <input type="checkbox"/> WW SPECIALIST <input type="checkbox"/> HEARING AID SPECIALIST <input type="checkbox"/> LACTATION CONSULTANT <input type="checkbox"/> MUSIC THERAPIST	<input type="checkbox"/> NURSING HOME ADMINISTRATOR <input type="checkbox"/> RESIDENTIAL CARE FACILITY ADMIN <input type="checkbox"/> POLYSOMNOGRAPHIC TECHNOLOGIST <input type="checkbox"/> RESPIRATORY THERAPIST <input type="checkbox"/> SEX OFFENDER THERAPY: <input type="checkbox"/> CLINICAL THERAPIST <input type="checkbox"/> SECONDARY ASSOCIATE THERAPIST <input type="checkbox"/> ASSOCIATE THERAPIST
<input type="checkbox"/> BODY ART PRACTITIONER: <input type="checkbox"/> BODY PIERCER <input type="checkbox"/> ELECTROLOGIST <input type="checkbox"/> TATTOOIST			

List licenses to be verified. (Oregon or other state(s))

ISSUING ENTITY (state, county, city, health dept., etc): _____	ISSUING ENTITY (state, county, city, health dept., etc): _____
STATE: _____ LICENSE# _____	STATE: _____ LICENSE# _____

To provide verification of your Oregon license to another state, please list the state's mailing information below.

STATE OR AGENCY NAME	PHONE
ADDRESS	
CITY	STATE ZIP

SIGNATURE:	Date:
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***Pursuant to OAR 331-030-0040(1)(a-d), applicants requesting an affidavit of licensure from Oregon to another state, or verification from another state to Oregon, must submit two forms of acceptable identification both of which must include the applicant's current legal name, at least one photographic; clear/legible photocopies of front and back if by mail. (See OAR 331-030-0000(6)(8)).**

*******HLO will not accept Personal or Business Checks for Affidavit of Licensure*******

Method of Payment: <input type="checkbox"/> Money order <input type="checkbox"/> Cashier's check <input type="checkbox"/> Purchase order	FEE = \$50.00 (per state) (No Fee for Licensed Dietitians)
Payment by Credit card: <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover	

NAME ON CARD LAST	FIRST	MIDDLE INITIAL
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CREDIT CARD NUMBER: (Do Not Fax or Email Credit Card Information)	EXPIRATION DATE:	AUTHORIZED AMOUNT: \$
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CARD HOLDER SIGNATURE:	Date:
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