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

Print Form

Authorization Holder Information Update

IMPORTANT: For all transactions listed below, you must provide one acceptable form of photographic identification, which includes applicant's current legal name. Front and back of legible (clear) photocopies if submitted by mail. Acceptable photographic identification options can be found under Oregon Administrative Rule, Chapter 331, Division 30.

☐ RENEWAL* ☐ LATE FEE* ☐ REPLACEMENT*

***Fees apply** – Visit www.healthoregon.org/hlo for listing of fees.

☐ CHANGE OF HOME ADDRESS ☐ CHANGE OF EMPLOYMENT

☐ NAME CHANGE ON PRACTITIONER LICENSE: **OR** ☐ CHANGE FACILITY LICENSE HOLDER TO NATURAL PERSON:

Print Practitioner Name Or Facility Owner Currently Listed On License _____(List new name below)

In addition to one form of acceptable photographic identification for name change on a practitioner license, you must also provide approved documentation filed in a court with appropriate jurisdiction. Pursuant to Oregon Administrative Rules, the holder of a facility license must be a natural person (list the natural person who will be the responsible facility license holder below).

☐ OTHER – please explain:

LICENSE / CERTIFICATION / REGISTRATION #:	EXPIRATION DATE (MM/DD/YYYY):
LICENSE / CERTIFICATION / REGISTRATION #:	EXPIRATION DATE (MM/DD/YYYY):
LICENSE / CERTIFICATION / REGISTRATION #:	EXPIRATION DATE (MM/DD/YYYY):

NAME: LAST FIRST MIDDLE INITIAL

RESIDENTIAL PHYSICAL ADDRESS **(REQUIRED)**:

CITY:	STATE:	ZIP:	DATE OF BIRTH:	SOCIAL SECURITY #**(REQUIRED)**

MAILING ADDRESS (if different from physical address):

CITY:	STATE:	ZIP:

PHONE: ☐ HOME ☐ CELL	BUSINESS TELEPHONE:	EMAIL:

Current Employer Information

PLEASE INDICATE: ☐ EMPLOYEE ☐ INDEPENDENT CONTRACTOR ☐ NOT CURRENTLY EMPLOYED

NAME OF FACILITY/COMPANY:	FACILITY LICENSE # (if licensed by OHLA):
ADDRESS OF FACILITY/COMPANY:	INDEPENDENT CONTRACTOR REG. # (if applicable):

CITY:	STATE:	ZIP:	TELEPHONE #:

Method of Payment (if required for renewal, late fee or replacement – see fees at www.healthoregon.org/hlo)

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)

INITIALS: _____ ☐ OTC ☐ VERIFIED ID ☐ APPROVAL CODE/CK#: _____

Return All Pages Of This Application And Keep A Copy For Your Records

Authorization Holder Information Update (continued)

Continuing Education and/or Survey – Self Attestation

I hereby attest that I have acquired _____ continuing education contact/credit hours required as a condition of my license renewal and that adequate proof of attainment is available for audit or investigation by the Health Licensing Office.

☐ I am a Licensed Dietitian and attest that I have completed the Oregon Health Policy and Research Survey online at: https://oregondas.allegiancetech.com/cgi-bin/qwebcorporate.dll?idx=SST5S9.

☐ I am a Licensed Respiratory Therapist and attest that I have completed the Oregon Health Policy and Research Survey online at: https://oregondas.allegiancetech.com/cgi-bin/qwebcorporate.dll?idx=7H8TPJ.

☐ I am a Licensed Polysomnographic Technologist and attest that I have completed the Oregon Health Policy and Research Survey online at: https://oregondas.allegiancetech.com/cgi-bin/qwebcorporate.dll?idx=FWXK5P.

Applicant Signature:	**Date**:

CPR/First Aid/Blood Borne Pathogens Training – Self Attestation

As a condition of license renewal I hereby attest that I hold a current certification a**nd** that adequate proof of the current certification is available for audit by the Health Licensing Office.in:

☐ Cardiopulmonary Resuscitation (CPR) **(Required for: Athletic Trainers, Certified Advanced Estheticians, Direct Entry Midwives, Body Piercers, and Tattoo Artists)**

☐ First Aid Training**;** and ☐ Blood Borne Pathogens Training **(Required for: Certified Advanced Estheticians, Body Piercers and Tattoo Artists)**

☐ Neonatal Resuscitation **(Required for: Direct Entry Midwives)**

Applicant Signature:	**Date**:

Replacement Request

☐ I have not received my license, certificate or registration. ☐ My license, certificate or registration was lost, stolen or destroyed.
Copy of photo identification which includes applicant's current and legal name is required. See 331-030-0000 (8) and (10). Legible (clear) photocopy of front and back if submitted by mail.

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).**

- Have you ever been convicted of a misdemeanor or felony? ☐ **Yes** ☐ **No**
  If yes, please list **all** convictions, including the charges as stated in the court documents and year convicted **(attach additional pages if necessary).**

	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.

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Individual Records Questions (continued)

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.

Applicant Signature: **Date**:

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 federal Health Care Integrity and Protection 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 Health Care Integrity and Protection Data Bank. 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.

Applicant Signature: **Date**:

IMPORTANT – A FRONT AND BACK COPY OF PHOTO ID, WHICH INCLUDES YOUR CURRENT AND LEGAL NAME, IS REQUIRED TO PROCESS YOUR PAPERWORK.