HEALTH LICENSING OFFICE
Lactation Consultant Program
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 Packet

LACTATION CONSULTANT LICENSE APPLICATION

IMPORTANT: You must submit **two** forms of acceptable identification as listed in OAR 331-030-0000(8), **both of which must include applicant's current legal name**. Front and back of legible (clear) photocopies if submitted by mail. Pursuant to OAR 331-030-0000(10) **at least one form of identification must be photographic**; driver's license, state ID card, passport or military ID card.

1. Applicant Information

APPLICANT NAME: LAST	FIRST	MIDDLE INTIAL

RESIDENTIAL PHYSICAL ADDRESS **(REQUIRED)**		
CITY	STATE	ZIP

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

PHONE: ☐ HOME ☐ CELL	BUSINESS TELEPHONE	EMAIL

GENDER ☐ Female ☐ Male	BIRTHDATE	SOCIAL SECURITY NUMBER (**REQUIRED**)

- Have you ever been known under any other name?
  ☐ **No** ☐ **Yes** – If yes, list full name(s):

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

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

Payment of Required Fees: Total of $200

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 ☐ ID Verified Credentialed: _____ ☐ IBCLC Certification

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3. 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.

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 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.

Applicant Signature:	**Date:**

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4. Affirmative Action – Voluntary Question

The State of Oregon has an Affirmative Action Policy. If you choose to provide this information, 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 information.

Ethnic Background (check only one)

☐ (A) **Asian or Pacific Islander**: Persons having origins in any of the peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. This area includes, for example, China, Japan, Korea, the Philippine Islands and Samoa.

☐ (B) **African American** (not of Hispanic origin): Persons having origins in any of the Black racial groups of Africa.

☐ (H) **Hispanic**: Persons of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish cultures or origin, regardless of race.

☐ (I) **American Indian or Alaskan Native**: Persons having origins in any of the original peoples of North America, and who maintain cultural identification through tribal affiliation or community recognition.

☐ (W) **Caucasian** (not of Hispanic origin): Persons having origins in any of the original peoples of Europe, North Africa or the Middle East.

APPLICATION REQUIREMENTS FOR LACATION CONSULTANT LICENSE

☐ Meet the requirements of OAR 331 Division 30;

☐ Submit a completed application form prescribed by the HLO, which must contain the information listed in OAR 331-030-0000 and be accompanied by payment of the required fees: Application fee = **$150; and** License fee = **$50;** for a total of **$200** (see payment section above);

☐ Submit **two** forms of acceptable original identification which must include applicant's current legal name and be issued by a federal, state or local government agency of the United States. At least one form of identification provided must be **photographic** identification as outlined in OAR 331-030-0000. Front and back of legible (clear) photocopies if submitted by mail; driver's license, state ID card, passport or military ID card;

AND

☐ Provide documentation of one of the qualifying pathways below.

☐ **PATHWAY ONE: QUALIFICATION THROUGH THE INTERNATIONAL BOARD OF LACATATION CONSULTANT EXAMINERS (IBLCE)**

Applicant must arrange for the IBLCE to send to the HLO:

☐ Documentation of being certified as an International Board Certified Lactation Consultant (IBCLC).

(OR)

☐ **PATHWAY TWO: QUALIFICATION THROUGH RECIPROCITY**

Applicant must:

☐ Meet the requirement in Pathway One; **and**

☐ Submit an affidavit of licensure pursuant to OAR 331-030-0040, for each state in which the applicant is licensed or certified, proving that the applicant is in good standing in every state.

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

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