OREGON HEALTH AUTHORITY

BIRTHING CENTERS

License Application Form
Health Care Regulation and Quality Improvement

Phone: 971-673-0540 Fax: 971-673-0556

Type of Action

New Facility* ☐ License Renewal* ☐ License # _____ Name/Address Change ☐	Ownership Change* ☐ Effective Date of Change: _____ Other ☐ (Specify) _____
* Fee Payment Required (See back of this form for amount)	

Facility Information

Facility Legal Name:		
Facility DBA Name (if applicable):		
Facility Physical Address, City, State & ZIP:		
Phone:	Fax:	County:
Facility Mailing Address (if different from above):		
Facility Email:		
Fiscal Year Ending Date (MM/DD) :		
Name of Administrator & Phone :		
Administrator Email:		
Emergency Contact Person & Phone:		
Days and Hours of Routine Operation:		

Owner Information

(If partnership or corporation, list each person having 5% or more interest on an additional page)

Individual ☐	Partnership ☐	Health District ☐	State ☐
Corporation ☐	County ☐	City ☐	Church ☐
Ownership Type: For Profit ☐ Non Profit ☐		Tax ID#:	
Name of Owner(s):			
Address, City, State & ZIP of Owner(s):			
Phone:	Fax:	County:	

I declare, under penalties of perjury, that I have examined this application and all attachments and that to the best of my knowledge and belief, this information is true, correct and complete. I will notify Health Care Regulation and Quality Improvement, in writing, of any changes in this information within 30 days of any such change.

Administrator's Signature	***Print Name***
Print Title	***Date (mm/dd/year)***

Flat Fee $750.00

*** Yearly Renewal Due By December 1st**

Make check payable to Oregon Health Authority and mail to:
Health Care Regulation and Quality Improvement
P.O. Box 14260
Portland, OR 97293-0260

HCRQI Office Use Only

Effective date of initial licensure: _____ Initials: _____ Date: _____

Renewal Licensure/Change: Approved: _____ Denied: _____ Withdrawn: _____

Initials: _____ Date: _____

CASH OFFICE: QC **793** initial/QC **795** renewal **50320 50435**