

Birthing Center License Form

Type of Action			
New Facility* <input type="checkbox"/>	Ownership Change* <input type="checkbox"/>		
License # <input type="checkbox"/>	Other (Specify): <input type="checkbox"/>		
License Renewal* (due 12/1) <input type="checkbox"/>	Effective Date of Change: <input type="checkbox"/>		
Name/Address Change <input type="checkbox"/>			

* Fee Payment Required (Flat Fee \$750.00)

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:		
Name of Administrator & Phone:		
Administrator Email:		
Emergency Contact Person & Phone:		
Emergency Contact Person Email:		
Days and Hours of Operation:		

Owner Information (If partnership or corporation, list each person having 5% or more interest on an additional page)			
Individual <input type="checkbox"/>	Partnership <input type="checkbox"/>	Health District <input type="checkbox"/>	State <input type="checkbox"/>
Corporation <input type="checkbox"/>	County <input type="checkbox"/>	City <input type="checkbox"/>	Church <input type="checkbox"/>
Ownership Type: For Profit <input type="checkbox"/>		Non- Profit <input type="checkbox"/>	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)

Make check payable to: Oregon Health Authority
Mail payment to: HFLC
PO Box 14260
Portland, OR 97293

Questions about this application?

Phone: 971-673-0540

Email: mailbox.hclc@state.or.us

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Renewal Licensure/Change: Approved: _____ Denied: _____ Withdrawn: _____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