Health Facility Licensing and Certification
800 NE Oregon Street, Suite 465
Portland, Oregon 97232
971-673-0540
971-673-0556 (Fax)

IHC Administrator Application*

***Please attach resume & background check request form to this application**

APPLICANT INFORMATION							
Last Name		First		M.I.	Date		
Street Address				Apartment/Unit #			
City		State		ZIP			
Phone		E-mail Address					

EDUCATION								
High School				Address				
From		To		Did you graduate?	YES ◯	NO ◯	Degree	
College				Address				
From		To		Did you graduate?	YES ◯	NO ◯	Degree	
Other				Address				
From		To		Did you graduate?	YES ◯	NO ◯	Degree	

Do you have two or more years of Management* experience in a health related field? YES ◯ (continue to section A) NO ◯

*Management experience means the administration, supervision or management of individuals in a health related field, including hiring, assigning, evaluating and taking disciplinary actions (OAR 333-536-0005(13)).

Do you have two or more years of Professional** experience in a health related field? YES ◯ (continue to section B) NO ◯

**Professional experience means having a nursing, medical, therapeutic license, certificate or degree used to work in a health related field (OAR 333-536-0005(21)).

SECTION A: MANAGEMENT EXPERIENCE* (USE SEPARATE PIECE OF PAPER IF NECESSARY)	
Company	Phone
Address	Supervisor
Job Title	
Management duties	
From _____/_____ To _____/_____	
Is this a health care related field? YES ◯ NO ◯	What field?_____
May we contact your previous supervisor for verification? YES ◯ NO ◯	
Company	Phone
Address	Supervisor

Job Title	
Management duties	
From _____/_____ To _____/_____	
Is this a health care related field? YES ◯ NO ◯ What field?_____	
May we contact your previous supervisor for verification? YES ◯ NO ◯	
Company	Phone
Address	Supervisor
Job Title	
Management duties	
From _____/_____ To _____/_____	
Is this a health care related field? YES ◯ NO ◯ What field?_____	
May we contact your previous supervisor for a reference? YES ◯ NO ◯	

SECTION B: PROFESSIONAL EXPERIENCE (USE SEPARATE FORM IF NECESSARY)**

Nursing/Medical/Therapeutic License, Certificate or Degree (Please include proof of Licensure, Certificate or Degree)
Date received?
License/Certificate Number?
License/Certificate Expiration Date?
Are you currently Licensed/Certified in Oregon? YES ◯ NO ◯
Are you currently Licensed/Certified in another state? YES ◯ NO ◯ What state?_____

DISCLAIMER AND SIGNATURE

I certify that my answers are true and complete to the best of my knowledge.

If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.

Signature Date

FOR HCRQI OFFICE USE ONLY

Administrator Approval

Name	Approve	Deny	Initials	Date
_____	☐	☐	_____	_____
_____	☐	☐	_____	_____
_____	☐	☐	_____	_____

Reason:_____

_____