



# HEALTH LICENSING OFFICE

1430 Tandem Ave. NE, Suite 180, Salem, OR, 97301  
Phone: 503-378-8667 | Fax: 503-370-9004  
[www.healthoregon.org/hlo](http://www.healthoregon.org/hlo) | Email: [hlo.info@state.or.us](mailto:hlo.info@state.or.us)

## **SUPPLEMENTAL APPLICATION FOR AUTHORIZATION TO PRACTICE THROUGH MILITARY TRAINING OR EXPERIENCE EQUIVALENCY**

An applicant seeking to use military training or experience as a qualification for applying for an authorization to practice a profession or occupation in a program administered under ORS 676.583 and ORS 676.800, must meet the qualifications for authorization as provided in the applicable statutes and rules of the program for which authorization is sought, and must submit a Joint Services Transcript, demonstrating completion of military training or experience that is substantially equivalent to requirements set forth in statute or rule by that program. This supplemental application must be submitted in addition to the application required by the specific program.

### **1. Applicant Information**

An application for authorization to practice, that is specific to the program for which you seek authorization, must be submitted prior to, or at the time of submitting this supplemental application. please indicate one of the following:

PROGRAM APPLICATION IS ATTACHED  PROGRAM APPLICATION WAS SUBMITTED ON THIS DATE:

PROFESSION FOR WHICH YOU MADE APPLICATION FOR AUTHORIZATION TO PRACTICE:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> ADVANCE ESTHETICIAN   | <input type="checkbox"/> DENTURE TECHNOLOGIST            | <input type="checkbox"/> MUSIC THERAPIST                                     |
| <input type="checkbox"/> ATHLETIC TRAINER      | <input type="checkbox"/> DIETITIAN                       | <input type="checkbox"/> NURSING HOME ADMINISTRATOR                          |
| <input type="checkbox"/> BODY ART PRACTITIONER | <input type="checkbox"/> DIRECT ENTRY MIDWIFE            | <input type="checkbox"/> RESPIRATORY THERAPIST/POLYSOMNOGRAPHIC TECHNOLOGIST |
| <input type="checkbox"/> BEHAVIOR ANALYST      | <input type="checkbox"/> ENVIRONMENTAL HEALTH SPECIALIST | <input type="checkbox"/> SEX OFFENDER THERAPIST                              |
| <input type="checkbox"/> COSMETOLOGY           | <input type="checkbox"/> HEARING AID DEALER              |  |

APPLICANT NAME: LAST FIRST MIDDLE INTIAL

MAILING ADDRESS

CITY STATE ZIP

PHONE:  HOME  CELL BUSINESS TELEPHONE EMAIL

I have attached a copy of my Joint Services transcript demonstrating completion of military training or experience that is substantially equivalent to requirements set forth in statute or rule by the program for which I am applying for authorization to practice.

**Applicant Signature:** \_\_\_\_\_ **Date** / /

**Do not write in this section – Official use only**

Initials \_\_\_\_\_  OTC  ID Verified  Program Application Attached  Joint Services Transcript Attached

### **REQUIREMENTS FOR SUPPLEMENTAL APPLICATION FOR AUTHORIZATION TO PRACTICE THROUGH MILITARY TRAINING OR EXPERIENCE EQUIVALENCY**

**To qualify under this rule for authorization to practice a profession or occupation in a program administered under ORS 676.583 and ORS 676.800, through military training or experience equivalency, an applicant must:**

- Meet all other qualifications for authorization as provided in the applicable statutes and rules of the HLO and program for which authorization is sought;
- Submit this Supplemental application, in addition to the application for authorization to practice required by the program for which you are applying; and
- Submit a Joint Services Transcript demonstrating completion of military training or experience that is substantially equivalent to requirements set forth in statute or rule by the HLO or the program for which you are applying.