PUBLIC HEALTH DIVISION
Health Care Regulation and Quality Improvement Section
Health Facility Licensing and Certification Program
healthoregon.org/hemo

Hemodialysis Technician Certification Application Form

Full Certification		Provisional Certification	
Initial *	◯	Initial *	◯
Renewal*	◯	Renewal*	◯
Name/Address Change	◯	Name/Address Change	◯

* Fee Payment Required (See Hemodialysis Technician Schedule & FAQ's)

Applicant Information (Please print clearly or use PDF Option)			
Name: Last:	First:	Middle:	Prior Names Used:
Mailing Address: Number and Street/Apt #:			
City:		State:	Zip:
Telephone:	Social Security Number**:		Date of Birth:
Email:			Gender:

As part of your application for certification issued by Health Care Regulation and Quality Improvement (HCRQI), you are required to provide your Social Security Number to HCRQI.* ***THIS IS MANDATORY FOR ALL INITIAL CERTIFICATIONS. *The Authority for this requirement is Oregon Laws 1977, Chapter 746, Section 117 (OAR 25.785) and 42 USC 666 (a)(13)*

Type of Test	**Please check one of the following boxes and indicate the date the test was passed.**	
BONENT	◯	
NNCC/CCHT	◯	
NNCO	◯	
Please check one below – ***Documentation of Completion <u>Required</u> for Initial Certifications ONLY***		
High School ◯		GED ◯

Hemodialysis Employers (Required for all certifications)			
List your hemodialysis employers, starting with the most recent			
Facility Name	Location	Dates of Employment	
		From:	To:
		From:	To:
		From:	To:
		From:	To:

Please answer all the following questions. "Yes" responses require a detailed written explanation. Attach additional pages to this application with responses. Failure to attach additional pages may result in a delay in certification. (*Required for All Certifications)*	
1. Do you have a physical, mental, or emotional condition(s) which may impair your ability to perform certified hemodialysis technician (CHDT) duties with the required skill and safety?	Yes ◯ No ◯
2. Have you ever been arrested, charged with, entered a plea of guilty, no contest, been convicted of, or sentenced for any criminal offense, either a misdemeanor or felony in any state?	Yes ◯ No ◯
3. Have you ever been investigated for any type of abuse in any state?	Yes ◯ No ◯
4. Have you ever been found guilty of violating any state and/or federal law and/or rule regulating health care?	Yes ◯ No ◯
5. Are any disciplinary actions **pending** against your CHDT certificate or its equivalent in any state or US jurisdiction?	Yes ◯ No ◯
6. Have any disciplinary actions **been taken** against your CHDT certificate or its equivalent in any state or US jurisdiction?	Yes ◯ No ◯
7. Has there ever been a civil judgment against you for incompetence, negligence, or malpractice in connection with the practice of health care?	Yes ◯ No ◯
8. Do you use, or have you used in the last five (5) years any chemical substance(s) that would in any way impair or limit your ability to perform as a CHDT with the required skill and safety?	Yes ◯ No ◯
9. Are you currently engaged in the illegal use of any controlled substance?	Yes ◯ No ◯
10. Have you ever been found in a civil, administrative, or criminal proceeding to have: a) Possessed, used, prescribed for use, or distributed controlled substances or prescription drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or prescription drugs, violated any drug laws or prescribed controlled substances for yourself? b) Committed any act involving dishonesty or corruption? c) Violated any state or federal law or rule regulating the practice of a health care profession?	 Yes ◯ No ◯ Yes ◯ No ◯ Yes ◯ No ◯
11. Have you ever had any certificate, license, registration, or other privilege to practice a health care profession denied, revoked, suspended, restricted, reprimanded, or censured?	Yes ◯ No ◯
12. Have you ever been placed on probation by state, federal or foreign authority?	Yes ◯ No ◯

Hemodialysis Training (*Required ONLY for ALL Initial Certifications)*			
Please provide documentation of the Hemodialysis training you have received. This should include classroom as well as clinical training. Attach additional pages to this application if necessary*. Manager Signature Required*			
Date	**Title**	**Sponsor**	**Time**

I hereby certify that the above-named individual and the information given is true and correct.

Manager Name ***Manager Signature*** ***Facility Name***

Hours Worked (*Required ONLY for Certification Renewals)*
Please use the provided section to list the number of hours worked during the current certification Period. *Hours worked need to be obtained during the current two-year certification period. Example: Hours need to be obtained through years 2017-2019 for Certification Renewal Year of 2019-2021. Manager Signature Required.*
Hours Worked

I hereby certify that the above-named individual and the information given is true and correct.

Manager Name ***Manager Signature*** ***Date (mm/dd/yyyy)***

Continuing Education (*Required ONLY for Certification Renewals)*

Please provide documentation of continuing education. This can include in-service trainings, conference, meetings, workshops, etc. Include the date of the event, the title of the event, the event sponsor, the length of time of each event, and any Continuing Education Units (CEU's) earned by your attendance. Attach a copy of the certificate(s) received upon completion.

For additional assistance on number of CEU's required please see our Hemodialysis Technician Fee Schedule & FAQ's online

PLEASE REVIEW YOUR APPLICATION FOR COMPLETENESS AND REQUIRED SIGNATURES

Falsifying an application, supplying misleading information, or withholding information is grounds for denial or revocation of certification.

I hereby certify that I am the above-named individual and that the information given is true and correct. ***In addition, if submitting an initial certification issued by Health Care Regulation and Quality Improvement (HCRQI), you are required to provide your Social Security Number to HCRQI. THIS IS MANDATORY FOR ALL INITIAL CERTIFICATIONS. The Authority for this requirement is Oregon Laws 1977, Chapter 746, Section 117 (OAR 25.785) and 42 USC 666 (a)(13)***

The Health Care Regulation & Quality Improvement (HCRQI) program will conduct a criminal record check through the Law Enforcement Data System (LEDS). Signature on this form indicates my consent for that criminal record check.

_____

Applicant Signature ***Date (mm/dd/yyyy)***

_____

Printed Name

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 **623** initial/QC **624** renewal

Background check clear date: _____ Needs additional documentation: Yes☐ No☐

Fee: _____ Hours: _____ CEUs: _____ Late Fee: _____