Health Facility Licensing and Certification
800 NE Oregon Street, Suite 465
Portland, Oregon 97232
971-673-0540
971-673-0556 (Fax)
Mailbox.inhomecare@odhsoha.oregon.gov

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(20)).

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(35)).

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 employer 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 employer 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

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

Reason: