



**Health Care Regulation & Quality Improvement**  
 800 NE Oregon Street, Suite 305  
 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 <input type="checkbox"/>	NO <input type="checkbox"/>	Degree		
College					Address				
From		To		Did you graduate?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Degree		
Other					Address				
From		To		Did you graduate?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	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 <input type="checkbox"/>	NO <input type="checkbox"/>	What field? _____
May we contact your previous supervisor for verification?			YES <input type="checkbox"/>	NO <input type="checkbox"/>	
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				
<u>Name</u>	<u>Approve</u>	<u>Deny</u>	<u>Initials</u>	<u>Date</u>
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Reason: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_