CUSTOMER INFORMATION UPDATE:

o RENEWAL o LATE FEE o CHANGE OF EMPLOYMENT o CHANGE OF NAME
o CHANGE OF HOME ADDRESS o OTHER________________________________

☐ Cosmetology	☐ Facility	☐ Independent Contractor
	☐ Esthetician	☐ Hair Designer
	☐ Nail Technician	☐ Barber
	☐ Hearing Aid Specialist	☐ Environmental Health Specialist
☐ Body Piercing	☐ Technician	☐ Respiratory Therapist
	☐ Facility	☐ Denturist
☐ Electrologist	☐ Practitioner	☐ Direct Entry Midwives
	☐ Facility	☐ Tattoo / Permanent Color ☐ Technician
☐ Athletic Trainer		☐ Facility

License / Certificate / Registration #: ________________________________ Expires: ______________

Name:____

Current Home Address: ____
City State Zip

Current Mailing Address :(if different)___________________________________
City State Zip

Social Security Number:______________ Birth date:______________ Telephone #:______________

Current Employer Information: Please indicate if you are an: o Employee o Independent Contractor o Not Currently Employed

Name of Facility:______________________________ Facility License #: ______________________

Address of Facility:____________________________ Telephone #:___________________________

City/ State/ Zip: _________________________ Independent Contractor Lic #: (if applicable):__________

Are you leaving previous employment? If yes, what was the name and facility number ______________________

Continuing Education – Self Attestation

I hereby certify that I have acquired _________ continuing education contact/credit hours required as a condition of license renewal and that adequate proof of attainment is available for audit or investigation by the Board.

Address Repositories

The Health Licensing Agency maintains two separate official repositories for address information. Notifying the office of a change of address will not automatically update both. Please indicate the appropriate list(s) to update.

☐ **Licensing database file**. This records individual practitioner information, used to generate renewal notices.
☐ **Administrative mailing list**. This is to notify interested parties of rulemaking and public meetings of the boards/councils.

Duplicate Request

I am requesting a duplicate license/certificate or registration. The reason for the request is:

☐ I have not received my license/certificate or registration. ☐ I have lost my license/certificate or registration.

☐ My license/certificate or registration was lost, stolen or destroyed.

I understand by paying this $_____ non-refundable duplicate fee, I will receive a duplicate license/certificate or registration. If my original license/certificate or registration is located after a new one is issued, I agree to destroy the duplicate or mail it back to the Health Licensing Agency in a timely manner.

Method of Payment - Credit cards cannot be accepted for the Board of Cosmetology - except over the counter

o Check o Visa o Mastercard o OTC
o Cash o Money Order INT_______

______________________ Credit Card Number (16 digits) ______/______ Expiration Date ______________ $ Amount Authorized

Write certificate / license number on check. Make checks payable to the Health Licensing Agency. Enclose exact amount. If postmarked after the expiration date, add the late fee.

Signature: ______________________________ Date: ______________________

Please mail to: Oregon Health Licensing Agency, 700 Summer St. NE, Suite 320, Salem, Oregon 97301-1287.