OREGON HEALTH AUTHORITY

Oregon State Hospital
Legal Affairs Office
2600 Center Street NE
Salem, OR 97301

# CERTIFIED FORENSIC EVALUATOR APPLICATION

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|---|---|
| ☐ INITIAL APPLICATION<br>☐ RECERTIFICATION | ☐ LICENSED PSYCHOLOGIST<br>☐ PSYCHIATRIST ☐ LCSW |

**Contact Information** (To be posted on website for public use)

Last name: First name:

Address:

| | | |
|---|---|---|
| City: | State: | E-mail: |

| | |
|---|---|
| Business Telephone: | OR License #: |

## EDUCATION

| College or University | Years Attended | | Degree Earned |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## CURRENT EMPLOYMENT INFORMATION

Name of Employer:

| | |
|---|---|
| City: | State: |

Phone:

## ATTACHED DOCUMENTS

| | |
|---|---|
| ☐ Curriculum Vitae | ☐ Supplement (Initial only) |
| ☐ Redacted evaluation reports<br>(3 for Initial, 2 for Recert) | ☐ Proof of current OR license |

## PAYMENT

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|---|---|
| ☐ $250 non-refundable application fee<br>Check or money order made out to Oregon State Hospital | Mail to: Attn: Business Office<br>Oregon State Hospital<br>2600 Center St NE<br>Salem, OR 97301 |

## APPLICANT'S CERTIFICATION

I hereby certify that all information provided in this application is true, complete, and accurate to the best of my knowledge. I understand that any false or misleading information may result in denial or revocation of my certification.

## SIGNATURE

Date: