

## Traditional Health Worker Full Certification and Renewal Application

### How to submit your application

**Note:** For quickest turnaround, fill out this form on a computer and submit it to [thw.program@odhsoha.oregon.gov](mailto:thw.program@odhsoha.oregon.gov). Applications sent by **mail** or **fax** may have a **delay of as much as 90 days**.

**We will only process fully completed applications.**

<b>Email</b> <i>(Best and quickest option)</i>	Attach this complete application and all supporting documents to an email. Send it to: <a href="mailto:thw.program@odhsoha.oregon.gov">thw.program@odhsoha.oregon.gov</a>
<b>Mail</b> <i>(Takes up to 90 days)</i>	Mail this completed application and all supporting documents to: Traditional Health Worker Program Oregon Health Authority Office of Equity and Inclusion 421 S.W. Oak St., Suite 750 Portland, OR 97204
<b>Fax</b> <i>(Takes up to 90 days)</i>	Fax this completed application and all supporting documents to 971-673-1128

### Who can receive a traditional health worker certification?

If you are one of the below worker types and want to receive traditional health worker (THW) certification, you must submit this completed application and all necessary documents to the Oregon Health Authority (OHA).

#### Traditional health worker's types include:

- Community Health Workers (CHW);
- Peer Support Specialists (PSS);
- Peer Wellness Specialists (PWS);
- Personal Health Navigators (NAV); and
- Birth Doulas.

#### Complete this application if you meet all of the following requirements:

- You are at least 18 years of age
- You have finished all required training for your worker type
  - Your training must be through an OHA-approved training program

**You must also submit the following for a THW certification:**

- A clear copy of a driver’s license, state-issued ID card or passport for your background check
- A copy of your training certificate
- A copy of your oral health training certificate
- A completed and signed application.

- Doulas are also required to submit an “OHA Approved Form for Birth Doula State Registry Certification” (OHA 8908D). To download this form, go to [https://www.oregon.gov/oha/OEI/Pages/THW\\_birthdoulas.aspx](https://www.oregon.gov/oha/OEI/Pages/THW_birthdoulas.aspx)

**Criminal background check process**

The OHA Office of Equity and Inclusion (OEI) will send your name to the Background Check Unit (BCU). The BCU will email you about completing a required “Background Check Application”. They may ask you to submit fingerprints. OEI will notify you by email if fingerprints are required.

For more information about the background check, go to:

<https://www.oregon.gov/oha/OEI/Pages/THW-Become-Certified.aspx> .

**Completing the process**

If OHA confirms you have met all requirements, OHA will notify you in writing of your certification as a THW. OHA will add your name and contact information to the registry of certified THWs.

**Our discrimination policy**

The Department of Human Services (DHS) and the Oregon Health Authority (OHA) do not discriminate against anyone. This means that DHS|OHA will help all who qualify and will not treat anyone differently because of age, race, color, national origin, gender, religion, political beliefs, disability or sexual orientation.

You may file a complaint if you believe DHS or OHA treated you differently for any of these reasons.

**Download the complaint form here:**

PDF form: <https://apps.state.or.us/forms/served/le8904.pdf>

Word form: <https://apps.state.or.us/forms/served/le8904.doc>

Please fill out as much information as you can. Attach copies of documents that help explain or support your complaint.

**Please send complaint forms to:**

OHA Office of Equity and Inclusion Diversity

Inclusion and Civil Rights Manager

421 S.W. Oak St., Suite 750

Portland, OR 97204

Fax: 971-673-1330 or email: [thw.complaints@odhsoha.oregon.gov](mailto:thw.complaints@odhsoha.oregon.gov)

Toll-free phone number: 1-844-882-7889 (voice) or 711 (TTY)

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact the Traditional Health Worker Program at 1-844-882-7889 or email [thw.program@odhsoha.oregon.gov](mailto:thw.program@odhsoha.oregon.gov). We accept all relay calls, or you can dial 711.

## 1 Applicant information

### 1.1 Application contact information \*All Fields Required

*First name	Middle name	*Last name		
Other names used		*Date of birth		
*Email ( <i>personal email recommended</i> )		*Preferred contact number		
*Mailing address	*City	*State	*ZIP	*County

**\*Make the following information publicly available on the Traditional Health Worker (THW) Registry:** Check all that apply, or “none” to indicate you do not want any of your personal or certification and credentials to show up on the Public Registry.

**Registry:** Check all that apply, or “none” to indicate you do not want any of your personal or certification and credentials to show up on the Public Registry.

- Name     
  Email Address     
  Phone Number     
  Mailing Address     
  None

### 1.2 Geographic availability: Where are you willing to work? (Choose as many locations as desired.)

Region 1	Region 2	Region 3	Region 5
<input type="checkbox"/> Clackamas <input type="checkbox"/> Clatsop <input type="checkbox"/> Columbia <input type="checkbox"/> Multnomah <input type="checkbox"/> Tillamook <input type="checkbox"/> Washington	<input type="checkbox"/> Benton <input type="checkbox"/> Lincoln <input type="checkbox"/> Linn <input type="checkbox"/> Marion <input type="checkbox"/> Polk <input type="checkbox"/> Yamhill	<input type="checkbox"/> Lane <input type="checkbox"/> Douglas <input type="checkbox"/> Coos <input type="checkbox"/> Curry	<input type="checkbox"/> Jackson <input type="checkbox"/> Josephine
Region 6	Region 7	Region 8	
<input type="checkbox"/> Hood River <input type="checkbox"/> Gilliam <input type="checkbox"/> Sherman <input type="checkbox"/> Wasco	<input type="checkbox"/> Crook <input type="checkbox"/> Deschutes <input type="checkbox"/> Grant <input type="checkbox"/> Harney <input type="checkbox"/> Jefferson <input type="checkbox"/> Klamath <input type="checkbox"/> Lake <input type="checkbox"/> Wheeler	<input type="checkbox"/> Baker <input type="checkbox"/> Malheur <input type="checkbox"/> Morrow <input type="checkbox"/> Umatilla <input type="checkbox"/> Union <input type="checkbox"/> Wallowa	

### 1.3 Work schedule availability:

**Days available:** (*Check all that apply.*)

- Sunday   
  Monday   
  Tuesday   
  Wednesday   
  Thursday   
  Friday   
  Saturday

Hours of availability: (Check all that apply.)		
<input type="checkbox"/> 7 a.m.–3 p.m.	<input type="checkbox"/> 3 p.m.–11 p.m.	<input type="checkbox"/> 11 p.m.–7 a.m.
<input type="checkbox"/> Morning	<input type="checkbox"/> Evening	
<input type="checkbox"/> Full-Time	<input type="checkbox"/> Part-Time	<input type="checkbox"/> Temporary

1.4 Languages (Read or Spoken)		
<input type="checkbox"/> African languages ( <i>specify</i> ):	<input type="checkbox"/> Italian	<input type="checkbox"/> Scandinavian ( <i>specify</i> ):
<input type="checkbox"/> Arabic ( <i>specify</i> ):	<input type="checkbox"/> Japanese	<input type="checkbox"/> Sign language ( <i>specify</i> ):
<input type="checkbox"/> Cantonese	<input type="checkbox"/> Korean	<input type="checkbox"/> Slavic ( <i>specify</i> ):
<input type="checkbox"/> Chinese ( <i>specify</i> ):	<input type="checkbox"/> Lao	<input type="checkbox"/> Somali
<input type="checkbox"/> Chuukese	<input type="checkbox"/> Mandarin	<input type="checkbox"/> Spanish ( <i>specify</i> ):
<input type="checkbox"/> English	<input type="checkbox"/> Marshallese	<input type="checkbox"/> Swahili
<input type="checkbox"/> French	<input type="checkbox"/> Mexican Indigenous Languages ( <i>specify</i> ):	<input type="checkbox"/> Tagalog
<input type="checkbox"/> German	<input type="checkbox"/> Mien	<input type="checkbox"/> Thai
<input type="checkbox"/> Guatemalan Indigenous Languages ( <i>specify</i> ):	<input type="checkbox"/> Mon-Khmer, Cambodian	<input type="checkbox"/> Urdu
<input type="checkbox"/> Hindi	<input type="checkbox"/> Persian	<input type="checkbox"/> Ukrainian
<input type="checkbox"/> Hmong	<input type="checkbox"/> Romanian	<input type="checkbox"/> Vietnamese ( <i>specify</i> ):
<input type="checkbox"/> Indic ( <i>specify</i> ):	<input type="checkbox"/> Russian	<input type="checkbox"/> Other ( <i>specify</i> ):

2 Optional questions: Race and ethnicity
<b>The following questions are optional and for data collection only. Information provided will have no effect on certification.</b>
1. How do you identify your race, ethnicity, tribal affiliation, country of origin, or ancestry?
2. Which of the following describes your racial or ethnic identity? Please check <b>all</b> that apply:
<b>American Indian or Alaska Native</b>
<input type="checkbox"/> Alaska Native <input type="checkbox"/> American Indian
<input type="checkbox"/> Canadian Inuit, Metis or First Nation
<input type="checkbox"/> Indigenous Mexican, Central American, or South American
<b>Hispanic or Latino/a</b>
<input type="checkbox"/> Hispanic or Latino Central American <input type="checkbox"/> Hispanic or Latino Mexican
<input type="checkbox"/> Hispanic or Latino South American <input type="checkbox"/> Other Hispanic or Latino ( <i>specify</i> ):
<b>Asian</b>
<input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino/a <input type="checkbox"/> Hmong

- Japanese                       Korean                       Laotian                       South Asian  
 Vietnamese                       Other Asian (specify):

**Native Hawaiian or Pacific Islander**

- Guamanian or Chamorro                       Micronesian                       Native Hawaiian                       Samoan  
 Tongan                       Other Pacific Islander (specify):

**Black or African American**

- African (Black)                       African American  
 Caribbean (Black)                       Other Black (specify):

**Middle Eastern or North African**

- Middle Eastern                       North African

**White**

- Eastern European                       Slavic                       Western European  
 Other White (specify): \_\_\_\_\_

**Other categories**

- Don't know/Unknown                       Other (specify): \_\_\_\_\_  
 Decline/Don't want to answer

If you selected more than one racial or ethnic identity above, please CIRCLE the ONE that best represents your racial or ethnic identity. If you have more than one primary racial or ethnic identity, please check here:

**2.2 Optional questions continued: Gender and Sexual Orientation**

**Gender**

- Male                       Female                       Transgender                       Other (specify):  
 Decline/Don't want to answer

**Sexual orientation (check one):**

- Gay or lesbian                       Straight, not gay or lesbian  
 Bisexual                       Queer                       Other (specify):  
 Decline/Don't want to answer

**2.3 Optional questions continued: Disability**

Your answers to the questions below help us find health and service differences among people with disabilities or limitations. Your answers are confidential.

Are you deaf or do you have serious difficulty hearing?

- Yes                       No                       Don't know                       Decline to answer

If yes, at what age did the condition begin? \_\_\_\_\_

Are you blind or do you have serious difficulty seeing, even when wearing glasses?

Yes  No  Don't know  Decline to answer

If yes, at what age did the condition begin? \_\_\_\_\_

Does a physical, mental or emotional condition limit your activities in any way?

Yes  No  Don't know  Decline to answer

If yes, at what age did the condition begin? \_\_\_\_\_

Do you have serious difficulty walking or climbing stairs?

Yes  No  Don't know  Decline to answer

If yes, at what age did the condition begin? \_\_\_\_\_

Do you have difficulty dressing or bathing?

Yes  No  Don't know  Decline to answer

If yes, at what age did the condition begin? \_\_\_\_\_

Because of a physical, mental or emotional condition, do you have serious difficulty concentrating, remembering, understanding or making decisions?

Yes  No  Don't know  Decline to answer

If yes, at what age did the condition begin? \_\_\_\_\_

## 2.4 Optional questions continued: Language

In what language do you want us to speak with you?

In what language do you want us to write to you?

Do you need an interpreter?  Yes  No

Do you need an interpreter because you are deaf, hard of hearing, or deaf-blind?  Yes  No

If yes, which type of interpretation (American Sign Language, video remote interpreting (VRI), tactile interpreting, etc.)?

Do you need written materials in an alternate (Braille, large print, audio recordings, etc.) format?

Yes  No

If yes, which format?

How well do you speak English?

Do not know  Very well  Well  Not well  Not at all

## 3.1 Application type

Application type:  New  Renewal

**THW type (check all that apply):**

**Submit one Application for all Renewals and one for all New Applications**

Birth Doula<sup>‡</sup>

Community Health Worker (CHW)

Peer Support Specialist (PSS):

PSS type:  Adult Addictions  Adult Mental Health  Family Support  Youth Support

Peer Wellness Specialist (PWS):

PWS type:  Adult Addictions  Adult Mental Health  Family Support  Youth Support

Personal Health Navigator (PHN)

- **†Birth Doulas:** You must submit the “Birth Doula State Registry Certification Checklist” (OHA 8908D). To download this form, go to [https://www.oregon.gov/oha/OEI/Pages/THW\\_birthdoulas.aspx](https://www.oregon.gov/oha/OEI/Pages/THW_birthdoulas.aspx)

### 3.2 Worker Roles Expectations

**In your role, do you expect to have direct contact with (*check all that apply*):**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Children                       | <input type="checkbox"/> Adults            | <input type="checkbox"/> Seniors ( <i>65 years and older</i> ) |
| <input type="checkbox"/> Confidential information       | <input type="checkbox"/> Secure facilities | <input type="checkbox"/> Finances/financial records            |
| <input type="checkbox"/> Information technology systems |  |  |

**In your role, do you expect to drive?**

- Yes  No

### 4.1 New Application Qualifications (Select any qualifications that could affect approval of your application)

Birth Doula Legacy Clause

Verifiable evidence must be submitted. Verification evidence means a pay statement, services contract, student practicum, volunteer time log, or other documentation reflecting hours worked or volunteered.

Driver’s license or passport or government issued ID

Legacy Clause

Legacy Clause: There may be a waiver for some training requirements when you provide proof that you worked or volunteered as a CHW/PWS/NAV in Oregon for at least 3,000 hours and 2,000 hours for PSS within the last five years of the date of this application. Describe this on the Work Experience page and upload the supporting documents. Must enter oral health training information on the Trainings page.

Reciprocity

Reciprocity: Attach a completed Reciprocity Form to this application. Must enter oral health training information on the Trainings page.

### 4.2 Renewal Application Qualifications

Competency test

Only required if the certification you are renewing has expired more than six months ago.

### 5.1 New Application Training 1 – Select type of training:

Select and enter training information one type at a time

#### Training types

- OHA-approved Community Health Worker training
- OHA-approved Peer Support Specialist training
- OHA-approved Peer Wellness Specialist training
- OHA-approved Personal Health Navigator training
- OHA-approved Birth Doula training — 28 hours core curriculum training (in-person or virtual or hybrid) in addition to:
  - Birth Doula — six contact hours in core Cultural Competency

<input type="checkbox"/> Birth Doula — four hours of Trauma-Informed Care training <input type="checkbox"/> Birth Doula — one hour of Health Insurance Portability and Accountability Act compliance training (HIPAA) <input type="checkbox"/> Birth Doula — one hour of Inter-Professional Collaboration <input type="checkbox"/> Birth Doula — CPR certification for infants, children, and adults <input type="checkbox"/> Oral health training
--

Training organization: Training name: City: State: Start date: Completion date: Total hours:
--

**You must attach documentation for all trainings that have been taken. If you need to enter more than two New Application Trainings – Attach a separate piece of paper. Attach training certificates for each training you list with this application.**

**New Application Training 2 – Select type of training:**

Select and enter training information one type at a time

<b>Training types</b> <input type="checkbox"/> OHA-approved Community Health Worker training <input type="checkbox"/> OHA-approved Peer Support Specialist training <input type="checkbox"/> OHA-approved Peer Wellness Specialist training <input type="checkbox"/> OHA-approved Personal Health Navigator training <input type="checkbox"/> OHA-approved Birth Doula training — 28 hours core curriculum training (in-person or virtual or hybrid) in addition to: <input type="checkbox"/> Birth Doula — six contact hours in core Cultural Competency <input type="checkbox"/> Birth Doula — four hours of Trauma-Informed Care training <input type="checkbox"/> Birth Doula — one hour of Health Insurance Portability and Accountability Act compliance training (HIPAA) <input type="checkbox"/> Birth Doula — one hour of Inter-Professional Collaboration <input type="checkbox"/> Birth Doula — CPR certification for infants, children, and adults <input type="checkbox"/> Oral health training
---

Training organization: Training name: City: State: Start date: Completion date: Total hours:
--

**5.2 Renewal Application Training 1 – Select type of training:**

Select and enter training information one type at a time

<b>Training types</b> <input type="checkbox"/> 20 hours Continuing Education Units (CEUs) <i>for each certification renewal</i>
--



- 40 hours Continuing Education Units (CEUs) for each certification renewal for PSS/PWS – Family Support and Youth Support Specialist ONLY.
- Three hours Suicide Prevention (part of your 20/40 CEUs)

Training organization:

Training name:

City:

State:

Start date:

Completion date:

Total hours:

**If you need to enter more than two Renewal Application Trainings – Attach a separate piece of paper. Attach training certificates for each training you list with this application.**

**Renewal Application Training 2 – Select type of training:**

Select and enter training information one type at a time

**Training types**

- 20 hours Continuing Education Units (CEUs) for each certification renewal
- 40 hours Continuing Education Units (CEUs) for each certification renewal for PSS/PWS – Family Support and Youth Support Specialist ONLY.
- Three hours Suicide Prevention (part of your 20/40 CEUs)

Training organization:

Training name:

City:

State:

Start date:

Completion date:

Total hours:

**For all new Legacy Clause and Birth Doula Legacy Clause Applications – you must enter the work or volunteer experience that allows you to claim this exemption from program required trainings. You do not have to enter work experience for new and/or Renewal Applications.**

**6 Work experience**

Organization: \_\_\_\_\_

Title: \_\_\_\_\_

Job Description:

Contact Person Name: \_\_\_\_\_

Contact Person Email: \_\_\_\_\_

Contact Person Phone: \_\_\_\_\_

Start Date: \_\_\_\_\_

End Date: \_\_\_\_\_

Total Hours Worked: \_\_\_\_\_

**Work experience**

Organization: \_\_\_\_\_

Title: \_\_\_\_\_

Job Description:

Contact Person Name: \_\_\_\_\_

Contact Person Email: \_\_\_\_\_

Contact Person Phone: \_\_\_\_\_

Start Date: \_\_\_\_\_

End Date: \_\_\_\_\_

Total Hours Worked: \_\_\_\_\_

**Work experience**

Organization: \_\_\_\_\_

Title: \_\_\_\_\_

Job Description:

Contact Person Name: \_\_\_\_\_

Contact Person Email: \_\_\_\_\_

Contact Person Phone: \_\_\_\_\_

Start Date: \_\_\_\_\_

End Date: \_\_\_\_\_

Total Hours Worked: \_\_\_\_\_

## 7 Code of ethics and signature

Please read the following statements carefully. Indicate your understanding and acceptance by signing below.

I agree to abide by the training and certification rules and traditional health worker standards of professional conduct. Refer to Oregon Administrative Rules (OAR) 410-181-0300 through 410-180-0388.

I understand that Oregon Health Authority (OHA) may deny, suspend or revoke certification status if I do not comply with Oregon Revised Statute (ORS) 414.665 or OAR 410-181-0300 through 410-180-0388.

I understand that I must apply to renew my certification status every three years. I must submit the renewal application no less than 60 days before my current certification period ends. I understand I will be removed from the registry if I fail to renew my certification within the renewal period. If I choose not to renew certification, I agree not to represent myself to potential employers or clients as a certified THW.

I certify that all the information contained in this application is true and accurate to the best of my knowledge and understanding. I understand that my application may be denied, or my certification may be revoked if I give false, incomplete, or misleading information.

---

Applicant signature	Applicant's printed name	Date
---------------------	--------------------------	------

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact the Traditional Health Worker Program at 1-844-882-7889 or email [thw.program@odhsoha.oregon.gov](mailto:thw.program@odhsoha.oregon.gov). We accept all relay calls, or you can dial 711.