OSHPD

STATE OF CALIFORNIA

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
Facilities Development Division
355 South Grand Avenue, Suite 1900
Los Angeles, CA 90071
Main Office (213) 897-0166
FAX (213) 897-1122

HOSPITAL INSPECTOR CERTIFICATION APPLICATION

(Must be printed or typed)

EXAM APPLYING FOR: (Refer to Title 24, Part 1, Article 19, Section 7-204 (a), (b) & (c))

☐ **CLASS "A"** ☐ **CLASS "B"** ☐ **CLASS "C"**

If applying for **Class "C"**, fill in SPECIALITY _____

OSHPD HOSPITAL INSPECTOR CERTIFICATION#_____
(IF APPLICABLE)

PREFERRED TEST LOCATION:

☐ LOS ANGELES AREA

☐ SACRAMENTO AREA

NAME: _____
LAST *FIRST* *M I*

MAILING ADDRESS: _____ ☐ Check if this is a change of address
NUMBER *STREET*

_____
CITY *COUNTY* *STATE* *ZIP CODE*

CONTACT: _( )_____ _____ _____
TELEPHONE NUMBER *E-MAIL ADDRESS*

CANDIDATES WITH DISABILITIES OR SPECIAL REQUESTS: If you have a disability or special need that restricts your ability to take a test under standard conditions you may request special testing arrangements. Clarification of both the disability and the need for special accommodations by a licensed medical doctor is required.

Do you have a disability/impairment for which you may need assistance during the examination? ☐ YES ☐ NO
IF "YES", YOU WILL BE CONTACTED TO MAKE SPECIFIC ARRANGEMENTS.

LIST CURRENT VALID LICENSES, CERTIFICATES AND MEMBERSHIPS IN PROFESSIONAL ASSOCIATIONS: ***(ATTACH COPIES)***

_____ _____ _____ _____

FORMERLY EMPLOYED BY OSHPD? ☐ YES ☐ NO IF "YES", DATE OF SEPARATION? _____

CONSTRUCTION / INSPECTION RELATED EDUCATION OR SEMINARS ATTENDED:

NAME AND LOCATION OF SCHOOL OR ORGANIZATION	COURSE OF STUDY	HOURS	DATE COMPLETED

EXPERIENCE: BEGINNING WITH YOUR MOST RECENT POSITION, PROVIDE DETAILS OF YOUR EXPERIENCE WHICH QUALIFIES YOU FOR ENTRANCE TO THIS EXAMINATION. RESUMES WILL NOT BE ACCEPTED IN LIEU OF THE APPLICATION.

LENGTH OF PROJECT ASSIGNMENT

FROM:_____ TO: _____

TOTAL:_____ YR._____ MO.

HOURS WORKED PER WEEK: _____

Description of inspection duties performed for:
Type(s) of Construction *(Circle)* **I II III IV V**

☐ Verification letter attached

NAME, ADDRESS & PHONE NO. OF EMPLOYER/CLIENT:

FACILITY NAME, BUILDING NAME & PROJECT COST:

EXPERIENCE CONTINUED:

LENGTH OF PROJECT ASSIGNMENT FROM:_________TO: __________ TOTAL:________YR.________MO. HOURS WORKED PER WEEK: __________	***Description of inspection duties performed for: Type(s) of Construction*** *(Circle)* **I II III IV V** ☐ Verification letter attached.	*NAME, ADDRESS & PHONE NO. OF EMPLOYER/CLIENT:* *FACILITY NAME, BUILDING NAME & PROJECT COST:*
LENGTH OF PROJECT ASSIGNMENT FROM:_________TO: __________ TOTAL:________YR.________MO. HOURS WORKED PER WEEK: __________	***Description of inspection duties performed for: Type(s) of Construction*** *(Circle)* **I II III IV V** ☐ Verification letter attached.	*NAME, ADDRESS & PHONE NO. OF EMPLOYER/CLIENT:* *FACILITY NAME, BUILDING NAME & PROJECT COST:*
LENGTH OF PROJECT ASSIGNMENT FROM:_________TO: __________ TOTAL:________YR.________MO. HOURS WORKED PER WEEK: __________	***Description of inspection duties performed for: Type(s) of Construction*** *(Circle)* **I II III IV V** ☐ Verification letter attached	*NAME, ADDRESS & PHONE NO. OF EMPLOYER/CLIENT:* *FACILITY NAME, BUILDING NAME & PROJECT COST:*
LENGTH OF PROJECT ASSIGNMENT FROM:_________TO: __________ TOTAL:________YR.________MO. HOURS WORKED PER WEEK: __________	***Description of inspection duties performed for: Type(s) of Construction*** *(Circle)* **I II III IV V** ☐ Verification letter attached	*NAME, ADDRESS & PHONE NO. OF EMPLOYER/CLIENT:* *FACILITY NAME, BUILDING NAME & PROJECT COST:*
LENGTH OF PROJECT ASSIGNMENT FROM:_________TO: __________ TOTAL:________YR.________MO. HOURS WORKED PER WEEK: __________	***Description of inspection duties performed for: Type(s) of Construction*** *(Circle)* **I II III IV V** ☐ Verification letter attached	*NAME, ADDRESS & PHONE NO. OF EMPLOYER/CLIENT:* *FACILITY NAME, BUILDING NAME & PROJECT COST:*

LENGTH OF PROJECT ASSIGNMENT	Description of inspection duties performed for: Type(s) of Construction (Circle) I II III IV V	NAME, ADDRESS & PHONE NO. OF EMPLOYER/CLIENT:
FROM:_____ TO: _____ TOTAL:_____ YR._____ MO. HOURS WORKED PER WEEK: _____	☐ Verification letter attached	FACILITY NAME, BUILDING NAME & PROJECT COST:
LENGTH OF PROJECT ASSIGNMENT	Description of inspection duties performed for: Type(s) of Construction (Circle) I II III IV V	NAME, ADDRESS & PHONE NO. OF EMPLOYER/CLIENT:
FROM:_____ TO: _____ TOTAL:_____ YR._____ MO. HOURS WORKED PER WEEK: _____	☐ Verification letter attached	FACILITY NAME, BUILDING NAME & PROJECT COST:

CERTIFICATION OF APPLICANT

I hereby certify that all statements made in this application are true and complete. I understand that any false statement will be cause for voiding this application and any subsequent certification. I further certify that I will not reveal the contents of the examination to anyone and affirm that I will abide by the rules of the examination. I understand that if I obtain OSHPD certification as a Hospital Inspector, my name, phone number, and e-mail address will be available to the public.

_____ _____

(SIGNATURE) *(DATE)*

FEE SCHEDULE

Check box for applicable fees submitted

SPACE)

Application Review (non-refundable).....	$100.00	☐
Exam for Class A Inspector Certification	$300.00	☐
Exam for Class B Inspector Certification	$300.00	☐
Exam for Class C Inspector Certification	$100.00	☐

TOTAL AMOUNT ENCLOSED $_____

METHOD OF PAYMENT

☐ MONEY ORDER ☐ CHECK – *PAYMENT MUST BE PAYABLE TO: OSHPD*

☐ VISA ☐ MASTERCARD ☐ AMERICAN EXPRESS ☐ NOVUS /DISCOVERCARD

CHARGE CARD NUMBER:_____ EXPIRATION.DATE:_____ CVC#_____

PRINT CARD HOLDER'S NAME: SIGNATURE:

BILLING ADDRESS: _____

CITY:_____ STATE:_____ ZIP CODE: _____

Mail payment and application to:

Office of Statewide Health Planning and Development Facilities
Development Division
Hospital Inspector Certification Program
355 South Grand Avenue, Suite 1900
Los Angeles, CA 90071

OFFICE USE ONLY
(DO NOT WRITE IN THIS)