HCAi Department of Health Care Access and Information
Office of Statewide Hospital Planning and Development
2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833
(916) 440-8300

HOSPITAL INSPECTOR CERTIFICATION EXAMINATION RETEST APPLICATION

(Must be 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", indicate Specialty:

_____

Current OSHPD Hospital Inspector Certification number:

PREFERRED TEST LOCATION:

☐ LOS ANGELES

☐ SACRAMENTO

_____

☑ **RETEST**

NAME: _____
LAST FIRST MI

ADDRESS: _____
NUMBER STREET

_____
CITY STATE ZIP CODE

CONTACT: (_____) _____
TELEPHONE NUMBER EMAIL ADRESS

CANDIDATES WITH DISABILITIES OR SPECIAL REQUESTS: *If you have a disability or impairment 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 professional is required.*

If you have a disability/impairment for which you need reasonable accommodation for the examination, you must submit PIN 61 with your application (found on our website).

CHANGE OF NAME, ADDRESS OR TELEPHONE

Pursuant to Title 24, Part 1, Article 19, Section 7-202, an applicant for the certification examination or a Hospital Inspector possessing a valid certificate issued by the Office, shall file name, mailing address or telephone number changes with the Office in Sacramento within 10 working days of that change. The information filed shall include both the new and former name, mailing address or telephone number.

CERTIFICATION OF APPLICANT

I hereby certify that all statements made in this application are true and complete. I understand that pursuant to the California Administrative Code Title 24, Part 1, Article 19, Section 7-214, the Office may suspend and/or revoke any certificate issued by the Office for incompetent inspection(s), inadequate inspection(s), misrepresentation(s), misconduct, and/or violation(s) of these regulations. I further certify that, in accordance with the California Administrative Code Section 7-208, I will not copy any portion of the exam, participate in collusion regarding the exam, disclose the contents of the examination questions to anyone other than a person authorized by the Office, solicit, accept, or compile information regarding the contents of the examination or falsify documents required for exam entrance. I understand that if I obtain HCAI certification as a Hospital Inspector, my name, phone number, and e-mail address will be available to the public.

_____ _____
Signature Date