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 CERTFICATION EXAMINATION
FEE PAYMENT FORM

The prescribed fees relative to the Hospital Inspector Certification Program shall be specifically charged to the applicant

RETEST Applications will be accepted from November 17, 2026 to February 1, 2027

RETEST Applications postmarked after the February 1, 2027 Final Filing Date will be returned.

RETEST Applications fees must be paid by **check, money order, or cashier's check** made payable to the Department of Health Care Access and Information (HCAI) and mailed to: HCAI - OSHPD
Hospital Inspector Certification Program
Attn: Suzy Rucobo
355 S. Grand Ave, Suite 1900
Los Angeles, CA 90071

Applicant Name:
RETEST Application Fee
Class A & Class B RETEST Application FEE $300.00 **Class C Retest Application Fee $100.00** **(Nonrefundable)**

California Health and Human Services Agency
Gavin Newsom, Governor

HCAI Department of Health Care Access and Information

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HOSPITAL INSPECTOR CERTIFICATION EXAMINATION RETEST APPLICATION

(Must be typed)

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

☐ CLASS "A" ☐ CLASS "B" ☐ CLASS "C"

Class "C", indicate Specialty:

_____

OSHPD Hospital Inspector Certification number Issued:

PREFERRED TEST LOCATION:

☐ LOS ANGELES

☐ SACRAMENTO

_____

☐ **RETEST**

NAME: _____
FIRST *MIDDLE INITIAL* *LASTI*

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 Los Angeles 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