



Addictions and Mental Health Division  
 500 Summer Street NE E86  
 Salem, OR 97301-1118  
 Fax: 503-378-8467  
 Email: Forensic.Certification@state.or.us

**CERTIFIED FORENSIC EVALUATOR APPLICATION**

INITIAL APPLICATION   
  RECERTIFICATION   
  LICENSED PSYCHOLOGIST   
  PSYCHIATRIST

Contact Information

Last name: \_\_\_\_\_ First name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: choose state \_\_\_\_\_ E-mail: \_\_\_\_\_

Business Telephone: \_\_\_\_\_

**EDUCATION**

College or University	Years Attended		Degree Date
	From	To	

Licensure # (attach copy of current license ) \_\_\_\_\_

**CURRENT EMPLOYER INFORMATION**

Please indicate:   
 Employee   
 Independent Contractor   
 Not Currently Employed

Name of Employer: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Phone: \_\_\_\_\_

**ATTACHED DOCUMENTS**

Complete Curriculum Vitae                     
 Psychiatry Supplement  
 \$250 non-refundable application fee                     
 Psychology Supplement  
 For Full Certification and re-certification, copies of three redacted evaluations for review panel

**APPLICANT'S CERTIFICATION**

The information above is offered in support of my application for Certification as a Forensic Evaluator. I understand that if my qualifications are satisfactory I will receive full or temporary certification.

**SIGNATURE**

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

**METHOD OF PAYMENT**

Check made out to OHA   
 Money Order   
 Other

AMH Process: \_\_\_\_\_ Documents Received  Yes  No

Date Received: \_\_\_\_\_ Notification Sent: \_\_\_\_\_