

**OREGON MEDICAL BOARD**

1500 SW 1<sup>st</sup> Ave, Suite 620 • Portland, OR 97201-5847

(971) 673-2700 or (877) 254-6263 (toll free in Oregon)

Web site address: [www.oregon.gov/OMB](http://www.oregon.gov/OMB)

Key 134 - Code 1340- Fee \$245.00

# APPLICATION FOR LICENSURE AS AN ACUPUNCTURIST IN THE STATE OF OREGON

- 1) Applications are valid for one year from the date filed. Submit this application with the \$245.00 filing fee (fee for applying only; additional fees for licensure will be due upon approval of your application). **FEES ARE NON-REFUNDABLE.** Make check payable to the "Oregon Medical Board" or complete the credit card information on the last page.
- 2) Upon completion of your application file and if you are eligible, you will receive written notification of your file's complete status with license registration paperwork. You may not register for licensure until you have completed the application process.
- 2) Read the attached instructions and application carefully. Answer ALL questions completely. Attach a separate typed sheet marked as an "Addendum to Application" and sign it, if needed.
- 3) If your application requires special review and final Board approval prior to licensure (*please see Acupuncture Licensure Overview [www.oregon.gov/OMB](http://www.oregon.gov/OMB)*), the following deadlines will apply to you:
  - o Application Filing Deadline: **October 23, 2009**
  - o File Completion Deadline: **November 6, 2009**
  - o Next Acupuncture Advisory Committee Meeting: **December 4, 2009**
  - o Next Oregon Medical Board Meeting: **January 15, 2010**

As part of your application for license or renewal of your registration, you are required to provide your Social Security Number to the Oregon Medical Board. This is mandatory. The authority for this requirement is ORS 25.785, ORS 305.385, 42 USC § 666(a)(13), 42 USC § 405 (c)(2)(i) and 45 CFR § 61.7 (3)(b). Failure to provide your Social Security Number will be a basis to refuse to issue or renew the license, certification or registration you seek. Your Social Security Number will remain on file with the Board, will be used for child support enforcement by Child Services Division, for tax administration, and required reports to the National Practitioner Databank and the Healthcare Integrity and Protection Databank (NPDB-HIPDB). The Board may also use your Social Security Number for identification and investigative purposes and for the collection of delinquent fines assessed by the Board.

1. FULL LEGAL NAME: (last, first, middle)	
2. OTHER NAMES YOU HAVE BEEN KNOWN BY:	5. SOCIAL SECURITY NUMBER:
3. HOME STREET ADDRESS:	6. HOME TELEPHONE:
4. CITY, STATE, ZIP:	
7. PRACTICE STREET ADDRESS:	8. BUSINESS TELEPHONE:
9. CITY, STATE, ZIP:	
10. E-MAIL ADDRESS:	
11. NAME OF ACUPUNCTURE TRAINING PROGRAM:	12. DIPLOMA DATE: (MM/DD/YY)
13. INTENDED PRACTICE FACILITY:	14. INTENDED PRACTICE CITY

15. LOCATION OF ACUPUNCTURE SCHOOL:	16. WAS YOUR ACUPUNCTURE PROGRAM ACAOM ACCREDITED OR IN CANDIDATE STATUS WHEN YOU GRADUATED? YES <input type="checkbox"/> NO <input type="checkbox"/>	17. NCCAOM CERTIFICATION DATE (MM/DD/YY) & NUMBER:
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**LIST ALL HEALTH RELATED LICENSES/CERTIFICATES YOU HAVE APPLIED FOR, HAD, OR STILL HAVE:**

TYPE OF LICENSE	STATE / COUNTY	LICENSE NUMBER	DATE ISSUED (MM/DD/YY)	DENIED (EXPLAIN)	Current	
					Yes	No

**EDUCATION, EMPLOYMENT, AND OTHER ACTIVITIES**

List all activities (employment, school, vacation, unemployment, moving, etc.) for the past ten years. **DO NOT leave a gap of more than one month** or you will be asked to provide written clarification. **Dates must be complete (month and year) or the application will be returned.** Employment verification will be required for all health-related employment (excluding self-employment) for the past five (5) years. Resumes are not accepted. Faxed verifications are not accepted.

NAME AND MAILING ADDRESS OF EMPLOYER AND OR DESCRIPTION OF ACTIVITY. (i.e. school, vacation, unemployed, traveling)	YOUR TITLE	FROM	TO
		(MM/DD/YY)	(MM/DD/YY)

ADDITIONAL SPACE ON NEXT PAGE



## PERSONAL HISTORY QUESTIONS

Review the Acupuncture Application Instructions when completing this section.

The answers to some of these questions may be exempt from public disclosure under ORS 192.505(2), the Oregon Public Records Law, unless a party seeking disclosure, by clear and convincing evidence, shows that disclosure would not be an unreasonable invasion of privacy and that the public interest requires disclosure in the particular instance. The answers to these questions may be considered by the Board and may be disclosed in any contested case hearing or appeal of a licensing decision based upon them.

Answer all questions. If you answer "yes" to any of the questions, you must provide a complete explanation of the event(s) or condition(s), including dates, names, addresses, circumstances, and results. Attach a written explanation or enter a written explanation in the "Comments" section on page 5.

**NOTE:** Fraud or misrepresentation in applying for or procuring a license, registration or reactivation in Oregon are grounds for disciplinary action, including denial or revocation of license, and are reported to the National Practitioner Data Bank and/or appropriate national professional credentialing organizations.

### CATEGORY I

YES NO

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Have you ever engaged in the unlicensed practice of any health care profession when you were required by law to have a license?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Have you ever failed a state or national examination or any portion of an examination to qualify for a state license to practice a health care profession?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Have you ever been asked to and/or permitted to withdraw an application for licensure, for credentialing, or for certification with any board, agency or institution?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Has any state licensing board refused to issue, refused to renew, or denied you a license to practice?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Have you ever had any disciplinary or adverse action imposed against any professional license or certification, or were you ever denied a professional license or certification, or have you entered into any consent agreement, stipulated order or settlement with any regulatory Board or certification agency; or have you ever been notified of any complaints or investigations related to any license or certification?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Have you ever been arrested, convicted of, or pled guilty or "nolo contendere" to ANY offense in any state in the United States or any foreign country, other than minor traffic violations?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Have you ever been contacted by or asked to make a response to any governmental agency in any jurisdiction regarding any criminal or civil investigation of which you are the subject, whether or not a charge, claim or filing with a court actually occurred?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Are you aware of any current, proposed, impending or threatened civil or criminal action against you? <i>This includes whether or not a claim, charge or filing was actually made with a court.</i>  |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Have you ever entered into any formal, informal, out-of-court or confidential settlement to deter, prevent, or settle a claim, lawsuit, letter of intent to sue, and/or criminal action? <i>This includes whether or not a claim, charge or filing was actually made with a court.</i>   |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Has any award, settlement or payment of any kind ever been made by you or on your behalf to resolve a malpractice claim, even if it was not required to be reported to the National Practitioner Data Bank (NPDB); or have you ever been notified in any manner that any such claim is proposed, pending or threatened, whether or not a claim, charge or filing was actually made with a court?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you interrupted the practice of your health care profession for one year or more, or ceased the practice of your specialty?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. Have you ever been restricted, suspended, terminated, requested to voluntarily resign, placed on probation, counseled, received a warning or been subject to any remedial or disciplinary action during a medically related training program?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you ever had privileges denied, reduced, restricted, suspended, revoked, terminated or have you been placed on probation, been subject to staff disciplinary action or non-renewal of an employment contract, or been requested to voluntarily resign or suspend your privileges while under investigation from a hospital, clinic, surgical center, or other medically related employment; or have you ever been notified that such action or request is pending or proposed? |

## CATEGORY II

“Illegal drug use” means the use of an illegally obtained controlled substance or dangerous drug; the term “illegal drug use” also means the use of a legally obtained controlled substance or dangerous drug, which is not taken in accordance with the directions of the licensed health care professional, who prescribed the controlled substance or dangerous drug.

**YES**    **NO**

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Do you currently, or have you had within the past 5 years, any physical, mental, or emotional condition, which impaired, or does impair your ability to practice your health care profession safely and competently? Has there been any type of inquiry into your physical, mental, or emotional health within the past 5 years?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Within the past 5 years, have you been admitted to any hospital or other in-patient care facility for any physical, mental, or emotional condition?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Do you currently have, or have you had within the past 5 years, a dependency on the use of alcohol or drugs, which impaired, or does impair, your ability to practice your health care profession safely and competently?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Within the past 5 years, have you engaged in the excessive or habitual use of alcohol or illegal drugs, or received any in-patient therapy/treatment or been hospitalized for alcoholism, or illegal drug use, or been arrested for a DUII (Driving Under the Influence of Intoxicants) or DWI (Driving While Intoxicated)? <i>“Excessive” as used in this question means the use of alcohol or drugs that leads to disturbances, fights, arrest, injury, accident, illness, loss of consciousness, or other adverse consequences.</i>                               |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Within the past 5 years, have you been the subject of any chemical substance screening test which resulted in an indication of the presence in your body of any controlled substance, any dangerous drug, or alcohol level above .08% BAC? Have you refused to submit to any such test? <i>This does not include those drugs taken by you as a result of a legitimate health care diagnosis, and prescribed for you in good faith by another licensed health care professional, unless the test was conducted as part of a criminal investigation, such as DUII.</i> |

**Comments:** (Attach separate sheet(s) of paper as needed.)

**IDENTIFICATION**

**SIGN AND DATE FRONT OF PHOTO AND ATTACH IT BELOW**

16. GENDER: \_\_\_\_\_

17. HEIGHT: (ft. & in.) \_\_\_\_\_

18. WEIGHT (lbs.) \_\_\_\_\_

19. HAIR COLOR: \_\_\_\_\_

20. EYE COLOR: \_\_\_\_\_

21. DATE OF BIRTH: \_\_\_\_\_  
*(Month) (Day) (Year)*

22. PLACE OF BIRTH: \_\_\_\_\_  
*(City) (State) (Country)*

Photograph must be a 2" x 2" original passport quality photo, taken within 90 days of application, signed in ink showing date taken on front side. Instant Polaroid snapshots with thick backing are NOT acceptable. Computer scanned photos are NOT acceptable.

**REQUESTED LICENSE STATUS (Check Appropriate Box)**

<input type="checkbox"/> <b>Active</b> (Practicing in Oregon)	<input type="checkbox"/> <b>Inactive</b> (Not Practicing in Oregon)	<input type="checkbox"/> <b>Locum Tenens</b> (Practicing intermittently in Oregon, no more that 240 days every 2 years with official residence outside Oregon)
<input type="checkbox"/> <b>Emeritus</b> (Volunteering services without remuneration)	<input type="checkbox"/> <b>Military/Public Health Active</b> (Practicing in the military or US Public Health service with official residence in Oregon)	

**RELEASE/AFFIDAVIT OF APPLICANT**

I, \_\_\_\_\_, being first duly sworn, depose and say that I am  
(Applicant, TYPE or PRINT full legal name)  
the person above described and identified; that I have not engaged in any of the acts prohibited by the statutes of the state of Oregon, particularly those acts set forth in Sections ORS 677.080 or 677.190.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates, business associations (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign), which includes state health licensing boards, to release to this licensing board any information, files or records requested by this board in connection with the processing of this application. I further authorize this board to release to the organizations, individuals and groups listed above any information, which is material to my application or pertinent to my practice of acupuncture during the processing of this application and the time that I am a licensee of this board.

I have read carefully the questions in the foregoing application and I have answered them completely, without reservation of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act is grounds for the denial, suspension or revocation of my license to practice acupuncture in the state of Oregon.

\_\_\_\_\_  
Sign your name in presence of a Notary

***This portion to be completed by notary***

Subscribed and sworn to before me on \_\_\_\_\_

Notary Signature \_\_\_\_\_

Notary Public for \_\_\_\_\_ Commission expires \_\_\_\_\_

*Notary Seal or Imprint*

**CREDIT CARD INFORMATION ON LAST PAGE**

