

REACTIVATION OF LICENSE

Applicant Name: _____
(PLEASE TYPE or PRINT LEGIBLY)

MALPRACTICE / MEDICAL PROFESSIONAL CLAIMS INFORMATION

Furnish information on separate sheet for each malpractice claim. Make copies of this form if necessary. Print or write legibly.

NAME OF PATIENT: _____

DATE OF INCIDENT: _____

LOCATION (HOSP, ETC.): _____

ALLEGATION: _____

CONDITION / DIAGNOSIS
AT TIME OF INCIDENT: _____

DESCRIPTION OF MEDICAL
TREATMENT RENDERED: _____

CONDITION OF PATIENT
SUBSEQUENT TO
TREATMENT: _____

DISPOSITION OF CLAIM: _____
(Include settlement amount)

DISPOSITION BY MEDICAL
BOARD IF APPLICABLE: _____

APPLICANT SIGNATURE: _____ DATE: _____

REACTIVATION OF LICENSE

Applicant Name: _____
(PLEASE TYPE or PRINT LEGIBLY)

WRITTEN EXPLANATION OF "YES" RESPONSES TO PERSONAL HISTORY QUESTIONS

Use this form to make the required written explanation concerning any affirmative responses to personal history questions. Use reverse side to provide required addresses. Make additional copies of this form if necessary. PRINT LEGIBLY OR TYPE YOUR RESPONSE. Refer to the instructions you received with the application which show the specific information needed, such as circumstances, results, etc., concerning each affirmative response. See separate form for response to the malpractice question.

Signature: _____ Date signed: _____

REACTIVATION OF LICENSE

Applicant Name: _____
(PLEASE TYPE or PRINT LEGIBLY)

Use this form to list the full names, mailing addresses, phone numbers, specific dates, etc., for any person, hospital, facility, etc., related to your affirmative responses to the personal history questions.

Question # _____
Name _____
Address _____
Phone Number _____ Dates _____
Area code

Question # _____
Name _____
Address _____
Phone Number _____ Dates _____
Area code

Question # _____
Name _____
Address _____
Phone Number _____ Dates _____
Area code

Question # _____
Name _____
Address _____
Phone Number _____ Dates _____
Area code

Question # _____
Name _____
Address _____
Phone Number _____ Dates _____
Area code

Question # _____
Name _____
Address _____
Phone Number _____ Dates _____
Area code

Use this page to provide an explanation to a "yes" response to any of the questions on page 1 of this Verification of Internship, Residency, Fellowship Training form.

1. Did the applicant take any leaves of absence or breaks from his/her postgraduate training?

2. Was the applicant ever placed on probation, disciplined, or under investigation?

3. Were any negative reports ever filed by instructors regarding the applicant?

4. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence, disciplinary problems, or any other reason?

5. Were there any concerns regarding the applicant's moral and ethical character, or use or abuse of alcohol, narcotics, barbiturates, amphetamines and/or other drugs?

6. Were there any concerns regarding the applicant's judgment, medical knowledge, performance or emotional stability?

Use this page to provide an explanation to a "yes" response to questions 1-4 or a "no" response to question 5 on page 1 of this Verification of Practice, Employment, Staff Membership form.

1. Were any limitations imposed on the privileges approved for the applicant?

2. Was the applicant ever revoked, suspended, restricted, limited, reprimanded, placed on probation or otherwise disciplined?

3. Was the applicant requested to voluntarily resign?

4. Were there any concerns regarding the applicant's judgment, medical knowledge, performance, or emotional stability?

5. If the applicant has/had staff privileges was the individual in good standing?

REACTIVATION OF LICENSE

OREGON MEDICAL BOARD
1500 S.W. 1st Avenue, #620, Portland, OR 97201-5847
(971) 673-2700

MD/DO/DPM LICENSURE - FAXED
RESPONSES NOT ACCEPTED

VERIFICATION OF LICENSURE AND CERTIFICATION OF STATE BOARD WRITTEN EXAMINATION GRADES

INSTRUCTIONS: Applicant who has ever applied for UNLIMITED licensure in any state must complete this form and send it directly to the State Board to be completed and returned to the OREGON MEDICAL BOARD. **Contact each state Board to determine required fee needed to be submitted with your request.**

Last Name First Name Middle Name

Other names you have been known by


Street Address

City, State, Zip

Date of Birth Social Security Number

License Number Date Issued

This is your authorization to release any information in your files, favorable or otherwise, to the OREGON MEDICAL BOARD.

 _____
Signature of Applicant Date signed

STATE BOARD TO COMPLETE THIS SECTION AND RETURN TO THE OREGON MEDICAL BOARD

License Number Date issued

Current Status Date Expired

- MD/DO/DPM**
- State Board Written Examination
 - National Board Examination
 - LMCC Examination
 - USMLE Examination (Steps 1, 2 and 3)
 - USMLE Examination (Combinations)
 - Reciprocity with _____

- OTHER** Dentist Nurse Physician Assistant Acupuncturist Other _____

Is applicant currently the subject of a pending investigation by a licensing or disciplining authority in your state?
 Yes No (If yes, please attach details).

Has the applicant's license ever been denied, limited, surrendered, reprimanded, suspended or revoked?
 Yes No (if yes, please attach certified copy of legal documents)

I certify that to the best of my knowledge, the information above is true according to the records of the Board.

Name _____

Title _____

Name of Board _____

Signature _____ Date Signed _____

REACTIVATION OF LICENSE

OREGON MEDICAL BOARD
1500 S.W. 1st Avenue, #620
Portland, Oregon 97201-5847

MD/DO/DPM LICENSURE
FAXED RESPONSES NOT
ACCEPTED

REQUEST FOR DISCIPLINARY INQUIRES - FEDERATION

ALL applicants for licensure must complete this form OR the form on the appropriate FEDERATION website below and forward it directly to the FEDERATION at the address shown below.

MD/DO APPLICANTS SEND TO:

DISCIPLINARY INQUIRIES
Federation of State Medical Boards
P.O. Box 619850
Dallas, TX 75261-9850
http://www.fsmb.org/fpdc_data_inquiry.html

NO FEE

DPM APPLICANTS SEND TO:

DISCIPLINARY INQUIRIES
Federation of Podiatric Medical Boards
6551 Malta Drive
Boynton Beach, FL 33437
<https://www.fpmb.org/orderreports/index.asp>

\$50 fee (CHECKS TO FPMB)

PLEASE PROVIDE A DISCIPLINARY SEARCH FOR:

Last Name

First Name

Middle Name

Other names you have been known by

Street Address

City, State, Zip

Date of Birth

Social Security Number (required for identification purposes)

Medical School of Graduation and Location

FEDERATION: PLEASE MAIL COMPLETED RESPONSE TO THE OREGON BOARD

Instructions for Registration of Oregon License REACTIVATION

Read Instructions **Before** Completing Reactivation Registration Form.

PLEASE NOTE: These instructions refer to the one-page reactivation registration form.

- Instructions are numbered to correspond to the numbers on the form.
- Business and addresses designated as mailing addresses are available to the public, under Oregon law (ORS192.420).
- For future addresses, please include **effective date**.
- Do not write in upper right hand box on application - for office use only.

APPLICATION FOR REGISTRATION

1. - 2. MAILING ADDRESS. Please write or type in the address that is the best address for our mail to reach you. This mailing address will be made available to the public. Check what type of mailing address it is (business, residence, or other). If you will be moving in the near future (next six months or so), please let us know the date when we should stop sending mail to this address. If you provide a PO Box, you must also provide the corresponding street or physical address, even if we will not be using it for mail delivery.

NOTE: A person's license to practice under this chapter automatically lapses if the licensee fails to notify the board of a change of location not later than the 30th day after such change. Refer to ORS 677.228 (1)(b).

3. NONREFUNDABLE FEES and STATUS.

- ✓ If you have been informed by Board staff (dee.hudnall@state.or.us) or (971) 673-2700, that you owe back registration renewal fees plus a late fee, write this amount next to the status you wish to have after you reactivate. These fees are nonrefundable and nontransferable; they cannot be credited or prorated. **NOTE:** You may not owe any registration fees if you have continued to pay the annual or biennial registration renewal fees.
- ✓ Oregon doctors pay registration fees on a biennial basis (once every two years). There are only two exceptions: Doctors in approved post-medical school training programs (residency) may pay their registration fees yearly. Doctors with Emeritus status must register yearly.
- ✓ Read status descriptions below to determine your status and check the appropriate choice on the **reactivation registration form**. There are five statuses described on this form: Active, Active-Military/Public Health, Inactive, Locum Tenens, and Emeritus. Read all descriptions (both sides of form) before marking your choice or calling us for assistance.
- ✓ Not all Oregon licensees are eligible for Active status under Oregon law (ORS 847-008-0015). Please contact our office if you have questions about your eligibility or need for a particular status. Email: omb.info@state.or.us or (971) 673-2700.

STATUS DEFINITIONS

• ACTIVE

Reserved for doctors who are or will be actively practicing medicine in Oregon within the next three (3) months, as evidenced by a business address (OAR 847-008-0015).

- ✓ Can be granted without a known business address for a period of three (3) months.
- ✓ Can be granted for doctors who will be arriving in Oregon after three months from reactivation date, who have a definite business address, and will be arriving within six (6) months of reactivation. (1 additional form required.)
- ✓ Can be granted to doctors living and/or practicing within certain bordering regions of California, Idaho, Nevada, or Washington. Call the Call Center for details.

• ACTIVE - MILITARY/PUBLIC HEALTH

For doctors who are in the military or public health service only (OAR 847-008-0015). This allows military/public health doctors to remain Active to meet military/public health service requirements, regardless of where they may be stationed. These doctors may register as Active – Military/Public Health under these conditions:

- ✓ Oregon must be the licensee's official state of residence. Please provide the official Oregon address.
- ✓ The licensee **must request** Military/Public Health status in the **form of a letter** accompanying the registration form and include a copy of their military identification card and a copy of their Defense Finance & Accounting Service Military Leave & Earnings Statement.
- ✓ The Active registration fee must be paid.
- ✓ Military/Public Health status prohibits Oregon practice, unless as directed by the military or public health authorities.
- ✓ Licensee must reactivate to unlimited Active status before beginning Oregon practice.
- ✓ Contact the Call Center staff for details. Email: omb.info@state.or.us or (971) 673-2700.

- **INACTIVE**

For doctors who are not living and practicing in Oregon, or for doctors living in Oregon, but not practicing medicine (OAR 847-008-0025).

- **LOCUM TENENS**

For doctors who do not live in Oregon or in bordering regions, but who plan on practicing intermittently within Oregon (OAR 847-008-0020). Locum Tenens doctors must notify the Board in advance and in writing of the dates, places, and telephone numbers of each Locum Tenens practice. A form for this purpose will be sent with the certificate of registration. It may be duplicated for your use. We accept notification by fax and by standard mail.

- **EMERITUS**

For doctors who do not practice medicine for pay or any other type of remuneration; these doctors volunteer their medical skills only (OAR 847-008-0030). These doctors must register annually.

NOTE: Physicians with Active-Military/Public Health service, Active-Teleradiology, Active-Telemonitoring, Inactive, or Locum Tenens status who move or return to Oregon to practice must complete an Affidavit of Reactivation and be granted Active status prior to beginning practice in Oregon.

4. **Enter your current business STREET address** or “as above” if it is the mailing address. **Enter your current business phone number.** If no business address, enter an appropriate remark, e.g., “pending,” “retired,” “none,” etc. **DO NOT LEAVE BLANK.** Enter FUTURE OREGON BUSINESS address and phone number if applicable. Enter date future business address is effective. Check **YES** or **NO** regarding your preferred mailing address at your future business address.

5. **Enter your current residence STREET address and phone number.** If mail cannot be delivered to this address, make notation in margin. **DO NOT LEAVE BLANK.** Enter FUTURE OREGON RESIDENCE street address and phone number if applicable. Enter date future residence address is effective. Check **YES** or **NO** regarding your preferred mailing address.

6. - 8. Enter the required information for these sections. A specialty list follows these instructions. **CHOOSE ONLY ONE SPECIALTY** from the list below. Since only one specialty can be listed, choose the specialty that best describes your primary practice. Check **YES** or **NO** regarding Board Certification for **THIS** specialty.

9. **DISPENSING DRUGS.** Definition: A “dispensing physician” is one who purchases prescription drugs for the purpose of dispensing them to patients or other individuals entitled to receive the prescription drug and who dispenses them accordingly.

Dispensing does **not** include distribution of free samples; drugs, vaccines, or other parenterals administered in the office; or writing prescriptions that will be filled at a pharmacy. Physicians or podiatric physicians who dispense drugs in Oregon without first registering with the Board may be fined \$100, and may be subject to further disciplinary action by the Board.

10. **OREGON STAFF PRIVILEGES.** Only active or locum tenens physicians complete item #10.

11. **LOCUM TENENS.** Complete if applicable. We will send you a form after your license is reactivated. Use this form to provide the Board with details of your upcoming Oregon practice (dates, phone numbers, and locations). You may make copies of the form as needed. Return the completed form to the Board **before each Locum Tenens position in Oregon.** You may mail or fax it to us.

12. **MD/DO/DPM SIGNATURE.** You must sign and date this form. Photocopies, stamps, or proxies are not acceptable.

SPECIALTY LIST.

Choose the one specialty that most closely describes your area of practice. (see **Registration #7**)

Acupuncturist..... ACUP	Dermatology..... D	Industrial Med..... IND	Oral Surgery..... OS	Preventative Med..... PM
Addiction Medicine... ADM	Diabetes..... DIA	Infectious Diseases.... ID	Orthopedic Surgery... ORS	Proctology PR
Adolescent Med..... ADL	Diagnostic Radiol..... DR	Internal Med..... I	Otology..... OT	Psychiatry P
Allergy..... A	Emergency Med..... EM	Legal Med LM	Oto/Laryn/Rhin..... OTO	Psychiatry Neurol..... PN
Allergy/Immunol..... AI	Endocrinology..... END	Max/facial Surgery... MFS	Pathology..... PATH	Psychoanalysis..... PYA
Anesthesiology..... AN	Family Medicine..... FM	Med Genetics..... GEN	Pediatrics..... PD	Psychoso Med..... PYM
Aviation Med..... AM	Forensic Pathology.... FOP	Neo/Perinatal Med.... NPM	Pediatric Allergy..... PDA	Public Health..... PH
Cardiology..... C	Gastroenterology..... GE	Nephrology..... NEP	Pediatric Cardiol..... PDC	Pulmonary Diseases... PUD
Cardiothoracic Surg... CDS	General Practice..... GP	Neurological Surg.... NS	Pediatric Endocrin.... PDE	Radiation Oncol..... TR
Cardiovascular Dis... CD	General Surgery..... GS	Neurology N	Pediatric Hem/Onc... PHO	Radiology..... R
Cardiovascular Surg...CDS	Geriatrics..... GER	Nuclear Med..... NM	Pediatric Nephrol.... PNP	Rheumatology..... RHU
Child Neurology..... CHN	Gynecology..... GYN	Nutrition.....NTR	Pediatric Radiology... PDR	Sports Med..... SM
Child Psychiatry..... CHP	Hand Surgery..... HS	Obstetrics..... OBS	Pediatric Surgery..... PDS	Therapeutic Radiol.... TR
Claims Adjudicator... CL ADJ	Head/Neck Surgery... HNS	Obstetrics/Gyn..... OBG	Pharmacology..... PHARM	Thoracic Surgery..... TS
Clinical Pathology.... CLP	Hematology..... HEM	Occupational Med.... OM	Phys Med & Rehab... PMR	Traumatic Surgery.... TRS
Colon/Rectal Surg.... CRS	Hospital Admin..... HAD	Oncology..... ONC	Plastic Surgery..... PL	Urology..... U
Critical Care Med..... CCM	Immunology..... IG	Ophthalmology..... OPH	Podiatrist..... DPM	Vascular Surgery..... VS

Application for Registration: Reactivating MD/DO/DPM

LICENSE #: _____ DATE LICENSED: _____ CURRENT STATUS: _____

REINSTATEMENT APPROVED FOR: Inactive PER: _____ EFFECTIVE: _____

REACTIVATION APPROVED FOR: Active Locum Tenens Emeritus PER: _____ EFFECTIVE: _____

Important: Please read instructions before completing application. All numbered items must be completed and form signed.

(1) **CURRENT MAILING ADDRESS** (Mailing address is available to the public):

(Last name) (MD/DO) (First) (Middle)

(Street address, PO box number, etc.)

(City) (State) (Zip)

(2) This mailing address is effective until: _____
() Practice
() Residence
() Other _____
(Billing, PO box number, etc.)

(3) **NONREFUNDABLE FEES:** Make check payable to "Oregon Medical Board" or complete credit card payment information on reverse side.

- _____ **ACTIVE** (Practice in Oregon or in Military/Public Health & Oregon is your official address, or practice from out-of-state via Teleradiology or Telemonitoring – Requires agency letter of verification)
_____ **INACTIVE** (Not practicing in Oregon.)
_____ **LOCUM TENENS** (See instructions and **complete item #11 below.**)
_____ **EMERITUS** (Retired, volunteer nonremunerative practice.)

(4) **CURRENT PRACTICE STREET ADDRESS:**

(5) **CURRENT RESIDENCE STREET ADDRESS:**

Current Practice Telephone #: _____

Current Residence Telephone #: _____

Will above address change in the near future? YES NO

Will above address change in the near future? YES NO

FUTURE PRACTICE STREET ADDRESS: Effective _____

FUTURE RESIDENCE STREET ADDRESS: Effective _____

Future Practice Telephone #: _____

Future Residence Telephone #: _____

Will above address be your **MAILING** address? YES NO

Will above address be your **MAILING** address? YES NO

(6) Oregon Practice County: _____

(7) Specialty: _____

(8) Board Certified by the ABMS (MD/DO), AOA (DO), or the ABPOPM or ABPS (DPM) in this specialty? YES NO
(Requires documentation in license file.)

(9) Will you purchase drugs to give or sell to your **Oregon** patients during the current registration period? YES NO
(**IMPORTANT** - see instructions for definition of dispensing physician)

(10) List all Oregon Staff privileges, permanent or pending, (hospital name and location) - Active or Locum Tenens physicians only:

(11) Licensees who wish Locum Tenens status - list conditions, dates, place and contact name of proposed Oregon practice **OR** list name, address and telephone number of Locum Tenens agency.

(12) I certify that the information submitted by me is true, accurate and complete to the best of my knowledge.

→ MD/DO/DPM Signature: _____ Date: _____

