

VERIFICATION OF PRACTICE, EMPLOYMENT, STAFF MEMBERSHIP

INSTRUCTIONS TO APPLICANT: Applicant to complete UPPER portion of form and forward to any hospital, clinic, emergency room, etc., where employed or where hospital staff membership has been requested. Source is to complete LOWER portion of form and return DIRECTLY to the OREGON BOARD.

Last Name	First Name	Middle Name	Social Security Number
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Name of Hospital, Clinic, Facility at the time of the association _____

Dates of Association	From (mo/day/yr)	To (mo/day/yr)
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Type of Association: Employee Staff Member Locum Tenens Emergency Room Instructor
 Other _____

I authorize the release of all pertinent information, favorable or otherwise, to the Oregon Medical Board.

Signature of Applicant _____

INSTRUCTIONS TO HOSPITAL/CLINIC/FACILITY: Please complete this form, sign and return it to the Board at the above address in an institution envelope. Please affix the seal of the hospital/institution. If the hospital/institution does not have a seal, so indicate. **All applicants for licensure have signed a general release, which relieves anyone of liability for information furnished in good faith.**

Type of Association: Employee Staff Member Locum Tenens Emergency Room Instructor
 Other _____

Dates of association: From (mo/day/yr) _____ To (mo/day/yr) _____

Unusual Circumstances: The following apply to unusual circumstances that occurred during the applicant's association with your facility. **If you answer "yes" to questions 1-4 or "no" to question 5, please explain briefly on page 2 of this form, and attach copies of any documentation.**

1. Were any limitations imposed on the privileges approved for the applicant? YES NO
2. Was the applicant ever revoked, suspended, restricted, limited, reprimanded, placed on probation or otherwise disciplined? YES NO
3. Was the applicant requested to voluntarily resign? YES NO
4. Were there any concerns regarding the applicant's judgment, medical knowledge, performance or emotional stability? YES NO
5. If the applicant has/had **staff privileges** was the applicant in good standing? YES NO

Affix Institutional Seal Here

Signature _____		
Print Name _____	Date Signed	/ /
Specialty Depart. _____		
Name of Facility _____		
Mailing Address _____		
City _____	State _____	Zip _____
Phone Number () _____		

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?
