Applicant Name: _____ Application No. _____

CHRONOLOGY OF ACTIVITIES FORM

If there are any gaps in your chronology longer than one month as provided on your application, please list activities for those gaps below. Verification is required for all health-related employment in the past five (5) years. Self-employment requires three (3) letters of reference from colleagues in the local treatment community who have known you for at least six months. Use additional pages as needed.

TYPE OF ACTIVITY (training, practice, employment, vacation)	**SPECIALTY or JOB TITLE**	**INSTITUTION OR PLACE OF PRACTICE AND LOCATION (City, State, Country)**	**FROM MM/DD/YYYY**	**TO MM/DD/YYYY**
EXAMPLES Residency	Internal Medicine	Yale Univ Sch Med, New Haven, CT, USA	7/1/98	6/30/00
Private Practice - Group	Family Practice	Maple Street Clinic, Stamford, CT, USA	7/1/00	11/15/06
Vacation / Traveling		Europe	12/10/08	2/1/09
Employment	Physician Assistant	Health First Med Ctr, San Francisco, CA, USA	4/25/07	Present

Send Information to:
Oregon Medical Board
1500 SW 1st Ave Suite 620
Portland, Oregon 97201
Email Address: omb.appdocuments@state.or.us

If emailing required documentation, please include in subject line:
Last Name, First Name, Application No. and the text “Required Documentation”