

OREGON MEDICAL BOARD

1500 SW 1st Ave, Suite 620 • Portland, OR 97201-5847
(971) 673-2700 or (877) 254-6263 (toll free in Oregon)
Web: www.oregon.gov/OMB

Above Space for Official Use Only
Key Code 1600
\$102

Date Lapsed/Inactive:	Date Reactivated:	Non-refundable Affidavit Fee \$102.00
-----------------------	-------------------	---------------------------------------

**REACTIVATION OF OREGON
PHYSICIAN ASSISTANT or ACUPUNCTURE LICENSE**

Physician Assistant license number: PA _____ Acupuncturist license number: AC _____

You may write one check for the total amount of the fees due (see enclosed Board letter) or complete the credit card information on page six. Make checks payable to "Oregon Medical Board."

- 1) This affidavit updates your licensure file from the date your license became inactive or lapsed until the present.
- 2) Please read this affidavit carefully and **answer all questions, and provide complete dates.** If an answer is "no" or "none" state so. If you require additional space, attach separate sheet.
- 3) 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 and 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.

GENERAL INFORMATION

FULL LEGAL NAME: (last, first, middle)		
OTHER NAMES YOU HAVE BEEN KNOWN BY:		SOCIAL SECURITY NUMBER:
HOME ADDRESS - Street, City, State & Zip Code:		HOME TELEPHONE:
PRACTICE ADDRESS - Street, City, State & Zip Code		BUSINESS TELEPHONE:
OREGON LICENSE NUMBER:	DATE ISSUED:	CURRENT/PREVIOUS BR OF MILITARY: _____ from _____ to _____ <i>branch</i>
E-MAIL ADDRESS:		
DATE AND REASON YOU EITHER LEFT THE STATE OF OREGON OR CHANGED YOUR STATUS TO INACTIVE:		
PRACTICE LOCATION PLANS IN OREGON:	DATE YOU WISH TO BEGIN PRACTICE:	

MEDICAL LICENSES/CERTIFICATES YOU HAVE PRACTICED UNDER, HAVE BEEN GRANTED, HAVE APPLIED FOR, OR HELD SINCE YOUR LICENSE BECAME INACTIVE or LAPSED

Verifications of licenses/certificates listed below are required directly from the issuing state or agency.

Type of License	State	Granted	Denied	Date Issued	Number	Current	
						Yes	No

CHRONOLOGY OF ALL ACTIVITIES SINCE YOUR LICENSE BECAME INACTIVE or LAPSED

You must complete this section. Attach separate sheet if needed. Dates must be complete (month, day, and year) or the affidavit will be returned. Do not leave a gap of more than one month or you will be asked to provide written clarification of the omission(s). Verification of all health related employment is required directly from the employer.

EMPLOYMENT OR OTHER ACTIVITY
With short description of employment/activity
NAME AND ADDRESS OF EMPLOYER

BEGIN DATE **END DATE**
(dd/mm/yy) *(dd/mm/yy)*

	Name: Address:				

PERSONAL HISTORY QUESTIONS

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 at the bottom of page 5.

NOTE: Fraud or misrepresentation in applying for or procuring a license, registration or reactivation in Oregon are grounds for disciplinary action, including a fine 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 denied approval to prescribe controlled substances, or been charged with a violation of federal or state narcotic laws, or been asked to surrender your DEA number? |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. 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"/> | 8. 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"/> | 9. 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"/> | 10. 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"/> | 11. 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"/> | 12. Have you interrupted the practice of your health care profession for one year or more, or ceased the practice of your specialty? |

- 13. Have you ever been restricted, suspended, terminated, requested to voluntarily resign, placed on probation, received a warning or been subject to any disciplinary action during a medically related training program?
- 14. 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? Have you been allowed to withdraw your staff privileges from a hospital or surgical center?

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

- 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?
- 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?
- 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?
- 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)? *“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.*
- 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? *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.*
- 6. Within the past five years, have you entered into a diversion program other than the Oregon Health Professionals Program for evaluation, treatment or monitoring for substance abuse or dependency, or for correction of communication or boundary issues, in lieu of or as a condition of resolving a matter before a health care program or facility, regulatory or licensing Board, or criminal or civil court; or have you been notified that such action is pending or proposed?

WRITTEN EXPLANATION CONCERNING “YES” RESPONSES TO PERSONAL HISTORY QUESTIONS

If you answered “YES” to any personal history question please furnish a thorough explanation, including dates, names and addresses, circumstances, results, and all copies of legal documents/letters. If there is not enough space, attach a signed and dated “Addendum.”

Category _____ Question # _____
Category _____ Question # _____

IDENTIFICATION INFORMATION

Gender: _____
Height: (ft. & in.) _____
Weight: (lbs.) _____
Hair Color: _____
Eye Color: _____
Date of Birth: _____
 (Month) (Day) (Year)
Place of Birth: _____
 (City) (State) (Country)

**SIGN AND DATE FRONT OF PHOTO
ATTACH PHOTO HERE**

Photograph must be a 2" x 2" original passport 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.

RELEASE/AFFIDAVIT OF APPLICANT

I, _____, being first duly sworn, depose and say that I am
(Licensee, 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 medical licensing boards, and the Federation of State Medical Boards, to release to this licensing board any information, files or records requested by this board in connection with the processing of this affidavit. I further authorize this board to release to the organizations, individuals and groups listed above any information which is material to my affidavit or pertinent to my practice of medicine or acupuncture during the processing of this affidavit 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 affidavit, I hereby agree that such act is grounds for the denial, suspension or revocation of my license to practice medicine or acupuncture in the state of Oregon.

Signature of Licensee (to be signed in the presence of Notary Public)

This portion to be completed by notary

Subscribed and sworn to before me on _____

Notary Signature _____

Notary Seal or Imprint Notary Public for _____ Commission expires _____

**THIS PAGE
INTENTIONALLY
LEFT
BLANK**

OREGON MEDICAL BOARD
1500 SW First Avenue, Suite 620
Portland, OR 97201-5847
Phone (971) 673-2700
www.oregon.gov/omb

Credit Card Payment

Note: All payment information is confidential, Oregon Medical Board use only.

_____		\$ _____
Company Name		Amount

Printed Name as it Appears on Card		
_____	_____	_____
Signature	Phone Number with Area Code	

Cardholder's Mailing Address		

<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Credit Card Number – VISA, MASTERCARD, OR DISCOVER	Expiration Date	Security Code