

OREGON MEDICAL BOARD
1500 S.W. 1ST AVE., Suite 620
Portland, Oregon 97201-5847
Phone (971) 673-2700
Fax (971) 673-2670

PRACTICE DESCRIPTION COPY REQUEST

Request Date _____

Mail copy of Practice Description to:

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PRACTICE DESCRIPTIONS REQUESTED		COST
Physician Assistant/License Number	Supervisor/License Number	
TOTAL AMOUNT DUE:		

OMB Use Only: Key Code 1560

PLEASE SUBMIT PAYMENT WITH REQUEST

Thank you!

Date service performed: _____ By: _____

