



Verification of Health Related Employment PA/AC Licensure

Revised 8/2016

INSTRUCTIONS TO APPLICANT: Complete UPPER portion of form and send directly to the employer. Employer is to complete LOWER portion of the form and return **DIRECTLY** to the OREGON MEDICAL BOARD.

Last Name _____ First Name _____ Middle Name _____

Other Names you have been known by _____ Date of Birth (mm/dd/yy) _____ Last 4 Digits of Social Security Number _____

Name of Employer _____ Address of Employer _____

Supervisor's Name & Title _____ Your Job Title _____ Employed FROM (mm/dd/yy) _____ Employed TO (mm/dd/yy) _____

I authorize the release of any information, favorable or otherwise regarding myself to the Oregon Medical Board. By signing this document, I release the employer and its representatives of liability for providing information to the Board.

Signature: _____ Date _____

INSTRUCTIONS TO EMPLOYER: Please complete this form, sign and return it to the Board at the address below in an institution envelope with your return address printed on it. **Faxed responses will NOT be accepted.**

Dates of Employment: FROM (mm/dd/yy) _____ TO (mm/dd/yy) _____ Employee's Job Title _____

If you answer "No" to question 1 or "Yes" to questions 2 through 5, please provide an explanation on page 2 of this form and attach copies of any documentation.

- 1. Is the employee eligible for rehire? YES NO
- 2. Was the employee ever requested to voluntarily resign from employment of subject to disciplinary action of any kind or ever had medical employment or hospital privileges denied, reduced, restricted, suspended, or terminated? YES NO
- 3. Were there any concerns regarding the employee's performance, medical knowledge, judgment, or work ethic? YES NO
- 4. Were there any concerns regarding abuse of alcohol, narcotics, barbiturates, amphetamines, and/or other drugs? YES NO
- 5. Were there any concerns regarding the employee's moral and ethical character? YES NO

Signature of Official _____

Print Name _____ Date: _____

Title _____

Name of Facility _____

Mailing Street _____

City _____ State _____ Zip _____

Phone Number _____

E-mail _____



Please use the spaces below to provide an explanation of any “No” response to question 1 or a “Yes” response to questions 2 through 5 on page 1 of this form. **Attach any supporting documentation and additional pages if necessary.**

1. Is the employee eligible for rehire?

2. Was the employee ever requested to voluntarily resign from employment of subject to disciplinary action of any kind or ever had medical employment or hospital privileges denied, reduced, restricted, suspended, or terminated?

3. Were there any concerns regarding the employee’s performance, medical knowledge, judgment, or work ethic?

4. Were there any concerns regarding abuse of alcohol, narcotics, barbiturates, amphetamines, and/or other drugs?

5. Were there any concerns regarding the employee’s moral and ethical character?
