



Verification of Active Medical Specialty Society Membership Distinguished Professor Licensure

INSTRUCTIONS TO APPLICANT: Complete UPPER portion of form and send directly to any two medical specialty societies where you hold current active membership. Organization is to complete LOWER portion of the form and return **DIRECTLY** to the OREGON MEDICAL BOARD.

Last Name First Name Middle Name

Organization Name Date of Birth (mm/dd/yy) Last 4 Digits of Social Security Number

I authorize the release of all pertinent information, favorable or otherwise, to the Oregon Medical Board. By signing this document, I release the organization and its representatives of liability for providing information to the Board.

Signature _____ Date _____

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

Organization Name Dates of Association: FROM (mm/dd/yy) TO (mm/dd/yy)

Please provide details regarding this medical specialty society's qualifications to obtain and maintain active membership.

Large empty box for providing details regarding the medical specialty society's qualifications to obtain and maintain active membership.

Signature _____ Date _____ Affix Seal Here if Available
Print Name _____
Title _____
Mailing Street _____
City _____ State _____ Zip _____
Phone Number _____
E-mail _____