



Verification of Internship, Residency, Fellowship Training MD/DO/DPM Licensure

Revised 02/2015

INSTRUCTIONS TO APPLICANT: Complete UPPER portion of form and send directly to any hospital/institution where training has been served. Training hospital/institution 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

Hospital/Institution name at the time of training FROM (mm/dd/yy) TO (mm/dd/yy)

I authorize the release of information, favorable or otherwise, from my postgraduate training program listed above, to the Oregon Medical Board. By signing this document, I release the program and its representatives of liability for providing information to the Board.

Signature: _____ Date _____

INSTRUCTIONS TO PROGRAM DIRECTOR: 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.** Please affix the seal of the hospital/institution; if hospital/institution does not have a seal, please so indicate.

Training	Postgraduate Level of Training						Specialty Department	FROM mm/dd/yy	TO mm/dd/yy
	<input type="checkbox"/> PG 1	<input type="checkbox"/> PG 2	<input type="checkbox"/> PG 3	<input type="checkbox"/> PG 4	<input type="checkbox"/> PG 5	<input type="checkbox"/> PG 6			
Internship	<input type="checkbox"/> PG 1	<input type="checkbox"/> PG 2	<input type="checkbox"/> PG 3	<input type="checkbox"/> PG 4	<input type="checkbox"/> PG 5	<input type="checkbox"/> PG 6			
Residency	<input type="checkbox"/> PG 1	<input type="checkbox"/> PG 2	<input type="checkbox"/> PG 3	<input type="checkbox"/> PG 4	<input type="checkbox"/> PG 5	<input type="checkbox"/> PG 6			
Residency	<input type="checkbox"/> PG 1	<input type="checkbox"/> PG 2	<input type="checkbox"/> PG 3	<input type="checkbox"/> PG 4	<input type="checkbox"/> PG 5	<input type="checkbox"/> PG 6			
Residency	<input type="checkbox"/> PG 1	<input type="checkbox"/> PG 2	<input type="checkbox"/> PG 3	<input type="checkbox"/> PG 4	<input type="checkbox"/> PG 5	<input type="checkbox"/> PG 6			
Residency	<input type="checkbox"/> PG 1	<input type="checkbox"/> PG 2	<input type="checkbox"/> PG 3	<input type="checkbox"/> PG 4	<input type="checkbox"/> PG 5	<input type="checkbox"/> PG 6			
Fellowship	<input type="checkbox"/> PG 1	<input type="checkbox"/> PG 2	<input type="checkbox"/> PG 3	<input type="checkbox"/> PG 4	<input type="checkbox"/> PG 5	<input type="checkbox"/> PG 6			

Unusual Circumstances: The following apply to unusual circumstances that occurred during any part of the applicant's training. Please check the appropriate response. **If you answer yes to any of these questions, please enclose an explanation on page 2 of this form and attach copies of any documentation.**

- | | | |
|---|------------------------------|-----------------------------|
| 1. Did the applicant take any leaves of absence or breaks from his/her postgraduate training? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2. Was the applicant ever placed on probation, disciplined, or under investigation? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 3. Were any negative reports ever filed by instructors regarding the applicant? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 4. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence, disciplinary problems, or any other reason? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 5. Were there any concerns regarding the applicant's moral and ethical character, or use or abuse of alcohol, narcotics, barbiturates, amphetamines and/or other drugs? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 6. Were there any concerns regarding the applicant's judgment, medical knowledge, performance or emotional stability? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

Program Director's Signature _____

Affix Institutional Seal Here

Print Name _____ Date: _____

Specialty Department _____

Name of Hospital _____

Mailing Street _____

City _____ State _____ Zip _____

Phone Number _____

E-mail _____



Please use the spaces below to provide an explanation of any “Yes” response to the questions on page 1 of this form. **Attach additional pages if necessary.**

1. Did the applicant take any leaves of absence or breaks from his/her postgraduate training?

2. Was the applicant ever placed on probation, disciplined, or under investigation?

3. Were any negative reports ever filed by instructors regarding the applicant?

4. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence, disciplinary problems, or any other reason?

5. Were there any concerns regarding the applicant’s moral and ethical character, or use or abuse of alcohol, narcotics, barbiturates, amphetamines and/or other drugs?

6. Were there any concerns regarding the applicant’s judgment, medical knowledge, performance or emotional stability?
