



# Request for Public Records

Revised 2/2017

## Requestor information:

Name		Date	
Company Name (if applicable)		Preferred Phone	
Mailing Address	City	State	Zip
E-mail	Method of delivery: <input type="checkbox"/> E-Mail <input type="checkbox"/> Postal mail <input type="checkbox"/> Personal Inspection		

### **Set-fee aggregate data (provided only by e-mail)**

*All reports are Comma Separated Value (CSV) format.*

<b>Licensees to Include:</b> <input type="checkbox"/> Physicians (MD/DO) <input type="checkbox"/> Podiatrists (DPM) <input type="checkbox"/> Physician Assistants (PA) <input type="checkbox"/> Acupuncturists (LAc)
<b>Statuses to Include:</b> <input type="checkbox"/> Practicing <sup>1</sup> <input type="checkbox"/> Non-Practicing <sup>2</sup>
<input type="checkbox"/> <b>Label Data \$50</b> Includes: • Licensee name • License number • Current mailing address • Practice phone and e-mail <sup>3</sup>
<input type="checkbox"/> <b>Standard List Data (includes Label Data) \$75</b> Includes: • License status and limitations • License original issue and expiration dates • Specialty • Medical school, location and graduation date • Practice address <sup>3</sup> , county <sup>4</sup> , phone and fax • Dispensing information • Birth year • Gender • Existence of Board Order • Other Licenses
<input type="checkbox"/> <b>Malpractice Information \$75</b> Includes: Licensee name • License number, issue date, and status • Specialty • Practice address <sup>3</sup> • Birth year • Total number of claims closed <sup>5</sup> • Insurer, claim number and settlement code • Reported date to insurer and closure dates • Date reported to Board • Allegation <sup>6</sup> • Patient gender and age • Institution and date of injury • Disposition • Economic, non-economic, punitive, and/or unspecified payments • Indemnity paid by all parties • Loss adjustment expense paid to defense counsel • All other loss paid
<p style="text-align: center;"><b><u>Custom requests</u></b></p> <p><i>As soon as practicable, Board staff will contact you with an estimate of costs based on the actual cost to the OMB to produce the records. Payment is required prior to production of records.</i></p> <input type="checkbox"/> <b>Custom Data \$75 + \$40/hour</b> <i>(provided only by e-mail)</i>
<input type="checkbox"/> <b>Meeting minutes, meeting audio, or other information</b> <b><i>Describe request. Be as specific as possible. Attach additional pages if necessary.</i></b>

<sup>1</sup> Practicing Statuses Include: Active, Active-One Year, Locum Tenens, Emeritus, Telemedicine Active, Telemonitoring Active, Teleradiology Active, Military/Public Health Active, and Administrative Medicine Active.

<sup>2</sup> Non-Practicing Statuses Include: Inactive, Inactive-One Year, Lapsed, Retired, Suspended, Surrendered, and Revoked.

<sup>3</sup> Not all licensees provide practice addresses, e-mail addresses, or phone numbers. If a licensee has more than one practice address on file, the most recently provided address will be included.

<sup>4</sup> Counties may be based on practice address zip code.

<sup>5</sup> Count derived from publicly available malpractice claims as reported to the OMB by malpractice insurers.

<sup>6</sup> If publicly available as outlined in ORS 742.400(5)(b).



# Request for Public Records

Revised 2/2017

## Fees for Public Records

All fees associated with public records requests must be paid in advance.

Charges are as follows:

1. Charges for copies: \$5/report + \$.20/page
2. Staff time, including time spent for research, collection of records, review of exemptions, redactions, separations, photocopying and supervision of any on-site record inspection is charged as follows:

Staff	Cost
Clerical	\$20/hour
Administrative	\$40/hour
Executive	\$50/hour
Medical Director	\$75/hour

3. Additional charges may be added for time spent by the Board's attorney to review, redact and segregate records, if necessary.

The Board's fee schedule is in Oregon Administrative Rule 847-005-0005.



# Request for Public Records

Revised 2/2017

## Credit Card Payment

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

**DO NOT E-MAIL CREDIT CARD PAYMENT FORM**

<hr/>		\$ _____ Amount
Company Name		
<hr/>		
Printed Name as it Appears on Card		
<hr/>		
Signature	_____	Phone Number with Area Code
<hr/>		
Cardholder's Mailing Address		
<hr/>		
Credit Card Number – VISA, MASTERCARD, OR DISCOVER	_____	Expiration Date