Verification of Practice, Employment, Staff Membership
MD/DO/DPM Licensure

Revised 10/2017

INSTRUCTIONS TO APPLICANT: Complete UPPER portion of form and send directly to any hospital, clinic, emergency room, etc. where employed or where hospital staff membership has been requested. Source 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, Clinic, Facility name at the time of association _____ Dates of Association: FROM (mm/dd/yy) _____ TO (mm/dd/yy) _____

Type of Association: ☐Employee ☐Staff Member ☐Locum Tenens ☐Emergency Room ☐Instructor
☐Other: _____

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

Signature: _____ Date _____

INSTRUCTIONS TO HOSPITAL/CLINIC/FACILITY: Please complete this form, sign and return it to the Board at the address below in an institution envelope. Please affix the seal of the hospital/facility; if hospital/facility does not have a seal, please so indicate. **Faxed responses will NOT be accepted.**

Type of Association: ☐Employee ☐Staff Member ☐Locum Tenens ☐Emergency Room ☐Instructor
☐Other: _____

Hospital, Clinic, Facility name at the time of association _____ Dates of Association: FROM (mm/dd/yy) _____ TO (mm/dd/yy) _____

Unusual Circumstances: The following apply to unusual circumstances that occurred during any part of the applicant's association with your facility. Please check the appropriate response. **If you answer "Yes" to questions 1 through 4 or "No" to question 5, please provide an explanation on page 2 of this form and attach copies of any documentation.**

1. Were any limitations imposed on the privileges approved for the applicant? ☐YES ☐NO
2. Was the applicant ever revoked, suspended, restricted, limited, reprimanded, placed on probation, or otherwise disciplined? ☐YES ☐NO
3. Was the applicant requested to voluntarily resign? ☐YES ☐NO
4. Were there any concerns regarding the applicant's judgment, medical knowledge, performance or emotional stability? ☐YES ☐NO
5. Is/was the applicant in good standing? ☐YES ☐NO

Signature _____ Affix Institutional Seal Here

Print Name _____ Date: _____

Specialty Department _____

Name of Facility _____

Mailing Street _____

City _____ State _____ Zip _____

Phone Number _____

E-mail _____

Please use the spaces below to provide an explanation of any "Yes" response to questions 1 through 4 or a "No" response to question 5 on page 1 of this form. **Attach any supporting documentation and additional pages if necessary.**

1. Were any limitations imposed on the privileges approved for the applicant?

2. Was the applicant ever revoked, suspended, restricted, limited, reprimanded, placed on probation, or otherwise disciplined?

3. Was the applicant requested to voluntarily resign?

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

5. Is/was the applicant in good standing?