Verification of Licensure and Certification of State Board Written Examination Grades

MD/DO/DPM Licensure

Revised 10/2017

INSTRUCTIONS TO APPLICANT: Complete UPPER portion of form and send directly to each State Board to which you have applied for an UNLIMITED License. State Board is to complete LOWER portion of the form and return **DIRECTLY** to the OREGON MEDICAL BOARD. **Contact each state Board to determine required fee to be submitted with your request.**

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	License Number	Date Issued (mm/dd/yy)
Street Address				
City, State, Zip Code				

I authorize the release of all pertinent information, favorable or otherwise, to the Oregon Medical Board.

Signature: _____ Date _____

INSTRUCTIONS TO STATE BOARD: Please complete this form, sign and return it to the Board at the address below. Please legibly affix the seal of the State Board. **Faxed responses will NOT be accepted.**

License Number	Date Issued (mm/dd/yy)	Current Status	Date Expired (mm/dd/yy)

MD/DO/DPM

- ☐ State Board Written Examination
- ☐ National Board Written Examination
- ☐ LMCC Examination
- ☐ USMLE Examination (Steps 1, 2, and 3)
- ☐ USMLE Examination (Combinations)
- ☐ Reciprocity with: _____

OTHER

- ☐ Dentist
- ☐ Nurse
- ☐ Physician Assistant
- ☐ Acupuncturist
- ☐ Other: _____

1. Is applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state? ☐YES ☐NO
   If yes, please attach details.
2. Has the applicant's license ever been denied, limited, surrendered, reprimanded, suspended, or revoked? ☐YES ☐NO
   If yes, please attach details.

I certify that to the best of my knowledge, the information above is true according to the records of the Board.

Affix Board Seal Here

Signature _____

Print Name _____ Date: _____

Title _____

Name of Board _____

Mailing Street _____

City _____ State _____ Zip _____

Phone Number _____

E-mail _____