



# Chronology of Activities Form

Revised 06/2024

Applicant Name: \_\_\_\_\_ Application No. \_\_\_\_\_

You are required to provide a full chronology of your activities from the time you graduated to present time. Verification is required for all health-related employment within the past five (5) years. Self-employment may require three (3) letters of reference from colleagues in the local treatment community who have known you for at least six months. Use additional pages as needed.

TYPE OF ACTIVITY (training, practice, employment, vacation)	SPECIALTY or JOB TITLE	INSTITUTION OR PLACE OF PRACTICE AND LOCATION (City, State, Country)	FROM MM/DD/YY	TO MM/DD/YY
EXAMPLES				
Residency	Internal Medicine	Yale Univ Sch Med, New Haven, CT, USA	7/1/98	6/30/00
Private Practice -Group	Family Practice	Maple Street Clinic, Stamford, CT, USA	7/1/00	11/15/06
Vacation / Traveling		Europe	12/10/08	2/1/09
Employment	Physician Associate	Health First Med Ctr, San Francisco, CA, USA	4/25/07	Present

## Send Information to:

Oregon Medical Board, 1500 SW 1st Ave Suite 620, Portland, Oregon 97201

Email Address: [omb.appdocuments@state.or.us](mailto:omb.appdocuments@state.or.us)

## If e-mailing required documentation, please include in subject line:

Last Name, First Name, Application No. and the text "Required Documentation"