



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

Revised 09/2015

**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?

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5. Is/was the applicant in good standing?

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