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

Revised 07/2021

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	DOB (mm/dd/yy)	Last 4 SSN

Hospital name at the time of association	Dates of Association:	From (mm/dd/yy)	To (mm/dd/yy)

Association Type: ☐ Employee ☐ Staff Member ☐ Locum Tenens ☐ Emergency Room
☐ 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. **Faxed responses will NOT be accepted.**

Association Type: ☐ Employee ☐ Staff Member ☐ Locum Tenens ☐ Emergency Room
☐ Other ______________________________

Hospital name at the time of association	Dates of Association:	From (mm/dd/yy)	To (mm/dd/yy)

Signature ______________________________

Print Name ______________________________ Date ______________

Title ______________________________

Facility Name ______________________________

Mailing Street ______________________________

City ______________________________ State ________ Zip ____________

Phone ______________________________

E-mail ______________________________

Please continue to page 2.

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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 and attach copies of any documentation.**

☐ I understand I am not required to provide the following information, and I ask that the following responses be kept confidential. If requested here, the Board will grant confidentiality for the below information.

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