Verification of Active Medical Specialty Society Membership
Distinguished Professor Licensure

Revised 07/2021

INSTRUCTIONS TO APPLICANT: Complete UPPER portion of form and send directly to any two medical specialty societies where you hold current active membership. Organization is to complete LOWER portion of the form and return DIRECTLY to the OREGON MEDICAL BOARD.

Last Name _____ First Name _____ Middle Name _____

Organization Name _____ DOB (mm/dd/yy) _____ Last 4 SSN _____

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 _____

NSTRUCTIONS TO ORGANIZATION: 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.**

Organization Name _____ Dates of Association: From (mm/dd/yy) _____ To (mm/dd/yy) _____

Please provide details regarding this medical specialty society's qualifications to obtain and maintain active membership.

Signature _____ Affix Seal Here

Print Name _____ Date _____

Title _____

Mailing Street _____

City _____ State _____ Zip _____

Phone _____

E-mail _____