OREGON STATE ATHLETIC COMMISSION
APPLICATION FOR MEDICAL PERSONNEL

I. PRACTITIONER INFORMATION

Last Name (include suffix; Jr., Sr., III):	First:	Middle:	Degree(s):

Is there any other name under which you have been known or have used since starting professional training? Yes ☐ NO ☐
Name(s) and Year(s) Used:

Home Street Address:	Home Telephone Number ( ) -	Mobile/Alternate Number ( ) -
	Email Address:	

City:	State:	ZIP:
Social Security Number*:	Birth Date: Month / Day / Year	Gender: Male ☐ Female ☐

Immigrant Visa Number (if applicable):	Visa Expiration Date	Status:	Type:

Educational Commission for Foreign Medical Graduates (ECFMG) Number (if applicable):	Month/Year Issued:

II. SPECIALTY INFORMATION

Principal clinical specialty: _____

Additional clinical practice specialties: _____

Do you have an active license in the state of Oregon? YES ☐ NO ☐
Have you ever been licensed in any other jurisdiction? YES ☐ NO ☐ Jurisdiction/State: _____

Category of professional activity, check all boxes that apply:

Clinical Practice:

- ☐ Full Time
- ☐ Part Time
- ☐ Locum/Temporary
- ☐ Telemedicine
- ☐ Other (explain)

Other Professional Activities:

- ☐ Administration
- ☐ Teaching
- ☐ Research
- ☐ Retired
- ☐ Other (explain)

In compliance with Public Law 93-5797 (5 USC 552(a)) you are hereby notified that the disclosure of a social security number is voluntary. If disclosed, it will be used for purposes of verifying your identity, medical credentials and qualifications, malpractice claims history, and disciplinary history pursuant to ORS 463.149(7)-(8) and OAR 230-020-0215. Refusal to provide a social security number may delay the processing of this application. This information may also be used for purposes of administering state, federal and local tax laws and enforcement of child support laws.

III. OTHER CERTIFICATIONS

Examples include: ACLS, BLS, ATLS, PALS

Type:	Month / Year of Certification:	Month / Year of Expiration:
Type:	Month / Year of Certification:	Month / Year of Expiration:
Type:	Month / Year of Certification:	Month / Year of Expiration:
Type:	Month / Year of Certification:	Month / Year of Expiration:

For additional certifications, please attach a separate sheet.

IV. PRACTICE INFORMATION

Name of Primary Practice/Affiliation or Clinic:	Time at Current Location:
Primary Clinical Practice Street Address:	Primary Clinical Practice Phone Number:
City: State: Zip:	
Name of Secondary Practice/Affiliation or Clinic:	Time at Current Location:
Secondary Clinical Practice Street Address:	Primary Clinical Practice Phone Number:
City: State: Zip:	

Please list other office locations with above information on a separate sheet.

V. Related Activity Background

Do you have any prior experience, personal or professional, in related activities such as boxing, MMA, martial arts, sports medicine, etc?

VI. ATTESTATION QUESTIONS - This section to be completed by the Practitioner.

Modification to the wording or format of these Attestation Questions will invalidate the application.

Please answer the following questions "yes" or "no". If your answer to any of the following questions is "yes", please provide details and reasons, as specified in each question, on a separate sheet. **Please sign and date each additional sheet.**

		Y	N
A	Has your license, certification, or registration to practice your profession, Drug Enforcement Administration (DEA) registration, or narcotic registration/certificate in any jurisdiction **ever been** denied, limited, suspended, revoked, not renewed, voluntarily or involuntarily relinquished, or subject to stipulated or probationary conditions, had a corrective action, or have you **ever been** fined or received a letter of reprimand or is any such action pending or under review?	☐	☐
B	Have you **ever been** suspended, fined, disciplined, or otherwise sanctioned, restricted or excluded for any reasons, by Medicare, Medicaid, or any public program or is any such action pending or under review?	☐	☐
C	Have you **ever been** denied clinical privileges, membership, or contractual participation by any health care related organization*, or have clinical privileges, membership participation or employment at any such organization **ever been** placed on probation, suspended, restricted, revoked, voluntarily or involuntarily relinquished or not renewed, or is any such action pending or under review?	☐	☐
D	Have you **ever** surrendered clinical privileges, accepted restrictions on privileges, terminated contractual participation or employment, taken a leave of absence, committed to retraining, or resigned from any health care related organization* while under investigation or potential review?	☐	☐
E	Has an application for clinical privileges, appointment, membership, employment or participation in any health care related organization* **ever been** withdrawn on your request prior to the organization's final action?	☐	☐
F	Has your membership or fellowship in any local, county, state, regional, national, or international professional organization **ever been** revoked, denied, limited, voluntarily or involuntarily relinquished or not renewed, or is any such action pending or under review?	☐	☐
G	Have you **ever** voluntarily or involuntarily left or been discharged from medical school or other medical training programs?	☐	☐
H	Have you **ever** had board certification revoked?	☐	☐
I	Have you **ever been** the subject of any reports to a state or federal data bank or state licensing or disciplinary entity?	☐	☐
J	Have you **ever been** charged with a criminal violation (felony or misdemeanor)?	☐	☐
K	Do you presently use any illegal drugs?	☐	☐
L	Do you now have, or have you had, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or is reasonably likely to affect your current ability to perform, with or without reasonable accommodation the duties of boxing or mixed martial arts medical personnel? If reasonable accommodation is required, please specify the accommodation(s) required on a separate sheet.	☐	☐
M	Are you **unable** to perform any of the duties of boxing or mixed martial arts medical personnel, with or without reasonable accommodation, according to accepted standards of professional performance?	☐	☐
N	Have any professional liability claims or lawsuits **ever** been closed and/or filed against you? If yes, please describe on a separate sheet.	☐	☐
O	Has your professional liability insurance **ever been** terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance?	☐	☐

e.g. hospital, medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), physician hospital organization (PHO), medical society, professional association, health care faculty position or other health delivery entity or system

I certify the information in this entire application is complete, current, correct, and not misleading. I understand and acknowledge that any misstatements in, or omissions from this application will constitute cause for denial of my application or if I am approved by OSAC to act as medical personnel, may constitute cause for withdrawal of my authorization as medical personnel for boxing or mixed martial arts events. A photocopy of this application, including this attestation, the authorization and release and any or all attachments has the same force and effect as the original. I have reviewed this information on the most recent date indicated below and it continues to be true and complete. I agree to update the information originally provided in this application should there be any change in the information.

Signature:_____ Date:_____

OREGON STATE ATHLETIC COMMISSION

APPLICATION FOR MEDICAL PERSONNEL

AUTHORIZATION AND RELEASE OF INFORMATION FORM

Modified Releases Will Not Be Accepted

By submitting this application, I understand and agree to the following:

1. I understand and acknowledge that, as an applicant for approval to participate as medical personnel at boxing and mixed martial arts events regulated by Oregon State Athletic Commission, I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and other qualifications. In this application, I have provided information on my qualifications, professional training and experience, prior and current licensure, Drug Enforcement Agency registration and history, and applicable certifications. I have disclosed and explained any past or pending professional corrective action, licensure limitations or related matter, if any. I have reported my malpractice claims history, if any.

2. I further understand and acknowledge that the State of Oregon or designated agent may investigate the information in this application. By submitting this application, I agree to such investigation and to the disciplinary reporting and information exchange activities as a part of the verification process.

3. I authorize all individuals, institutions, entities of other hospitals or institutions with which I have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status, to consult with the Oregon State Athletic Commission, or its designated representatives.

4. I consent to the inspection by the Oregon State Athletic Commission or its designated representative of records and documents that may be material to an evaluation of qualifications and my ability to carry out the duties of medical personnel I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews, if requested by the Oregon State Athletic Commission

5. I release from any liability, to the fullest extent permitted by law, OSAC, its members and employees, and all designated representatives of OSAC, for their acts performed in a reasonable manner in conjunction with investigating and evaluating my application and qualifications, and I waive all legal claims against any representative of the health care related organization(s) or their respective agent(s) who acts in good faith and without malice in connection with the investigation of this application.

6. I understand and agree that the authorizations and releases given by me herein shall be valid so long as I am approved to participate as medical staff at OSAC regulated events.

7. I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application.

Printed Name: _____

Signature: _____ Date: _____

I grant permission for the release of information that is material to an evaluation of my qualifications and malpractice and disciplinary history by health care, medical credentialing, or medical malpractice related organization(s) to the Oregon State Athletic Commission.

(This Section to be completed by Commission)

VII. PRACTITIONER INFORMATION

Last Name (include suffix; Jr., Sr., III):	First:	Middle:	Degree(s):

M.D. and D.O Applicants

1. NPI information matches above application: YES ☐ NO ☐
(https://npiregistry.cms.hhs.gov/NPPESRegistry/NPIRegistryHome.do)

2. Oregon License verified: YES ☐ NO ☐
(https://techmedweb.omb.state.or.us/Clients/ORMB/Public/VerificationRequest.aspx)

License is active? YES ☐ NO ☐
Expiration date:_____
License is unrestricted? YES ☐ NO ☐
Any malpractice claims on record? YES ☐ NO ☐

R.N and N.P Applicants

1. Oregon License verified: YES ☐ NO ☐
(http://osbn.oregon.gov/onlineverification/Search.aspx)

License is active? YES ☐ NO ☐
Expiration date:_____
Oregon State Board of Nursing (OSBN) Discipline YES ☐ NO ☐

P.A Applicants

1. NPI information matches above application: YES ☐ NO ☐
(https://npiregistry.cms.hhs.gov/NPPESRegistry/NPIRegistryHome.do)

2. Oregon License verified: YES ☐ NO ☐
(https://techmedweb.omb.state.or.us/Clients/ORMB/Public/VerificationRequest.aspx)

License is active? YES ☐ NO ☐
Expiration date:_____
License is unrestricted? YES ☐ NO ☐
Any malpractice claims on record? YES ☐ NO ☐

OSAC Training

Orientation:
Date: _____

Oriented by:_____

Competency Exam:
Date passed:_____

Approved as Medical Personnel: YES ☐ NO ☐

Monitoring:
Date: _____

Date:_____

Monitored by: _____

Authorizing Signature:_____