

OREGON MEDICAL BOARD
 1500 SW First Avenue, #620
 Portland, OR 97201-5847
 Phone (971) 673-2700
 www.oregon.gov/omb

PRACTICING UNDER A LOCUM TENENS LICENSE

As a licensee with Locum Tenens status, you are eligible to practice medicine in Oregon. Using this form, you must provide the Board with timely notification of the location and duration of each Oregon practice prior to beginning the practice (OAR 847-008-0020).

- ✧ You can report assignments to a single location, during one calendar month, on one Locum Tenens form.
- ✧ Use specific dates for beginning and ending dates. Terms like ‘on-going’ or ‘current’ are not acceptable.
- ✧ Please include the location where you will be practicing medicine, rather than the business or billing office.
- ✧ The licensee must sign this form before submitting by fax or mail. The Board cannot accept an unsigned form.

** In the Number of Practice Days box, please only indicate the number of days you will actually work within the beginning and ending dates you indicated. **Do not include your days off in this number.** ***

Licensees who live outside of Oregon and do intermittent Locum Tenens work in Oregon are not eligible for Active status.

A licensee with Locum Tenens status may practice in Oregon for 180 days within the biennial period. A licensee with Locum Tenens status who wishes to practice in Oregon for longer than 180 days, in the biennium, will need to reactivate the license to Active status. Contact Board staff immediately, to begin the reactivation process, if you believe you are nearing the 180 day limit.

If you hold Locum Tenens status as a Volunteer Camp Physician, you can practice in Oregon for up to 14 days per year at a pre-approved camp operated by a nonprofit organization.

A license with Locum Tenens status must be renewed biennially. If you do not practice in Oregon during each biennium, you are no longer eligible for Locum Tenens status. Your license will return to Inactive status at the time of registration renewal.

Please type or write legibly.

Licensee Name (Last)		(First)	(Middle I.)	Oregon License Number
Beginning Date of Oregon Practice	Ending Date of Oregon Practice		*** Number of Practice Days ***	
Name of Oregon Practice (Clinic, Hospital, etc.)				
Oregon Locum Tenens Practice Location		(Street address)		
(City)	(State)		(Zip)	
Oregon Locum Tenens Practice Telephone Number		(Area Code)	(Phone #)	
I hereby certify that I am the above named practitioner. The information submitted above is a true and accurate account of my plans to practice in Oregon under Locum Tenens status as of this date.				
Signature:			Date:	