OREGON BOARD OF MEDICAL EXAMINERS
1500 SW 1st Ave., Suite 620
Portland, OR 97201-5847
www.oregon.gov/bme

MD/DO LICENSE RENEWAL – 2008 - 2009

Payment Due by December 1, 2007 - License will Lapse on January 1, 2008

IMPORTANT: Please read Instructions before completing application. Information on this form is available to the public **EXCEPT** residence address (unless it is your mailing address), residence phone number, SSN, responses to Category I and II Registration Renewal Questions, & credit card data.

1. NAME AND CURRENT MAILING ADDRESS

2. OREGON LICENSE NO.

3. CURRENT STATUS

4. FEES & STATUS REQUESTED
PAYMENT BY CHECK OR CHARGE - SEE PAGE 4.

- ☐ ACTIVE $438.00
- ☐ LOCUM TENENS $438.00
- ☐ INACTIVE $438.00
- ☐ EMERITUS $ 50.00
- ☐ EMERITUS INACTIVE $ 50.00
- ☐ RETIRED **No Fee**

(You must be currently in a postgraduate training program to register Active/Inactive 1 year)

- ☐ ACTIVE (1 year) $219.00
- ☐ INACTIVE (1 year) $219.00

IS THE MAILING ADDRESS ABOVE CORRECT? ☐ **YES** ☐ **NO**
If NO, please provide current address below, including PO Box & PMB addresses.

Please read Instructions before checking below.
I do not wish to renew the registration of my license.

- ☐ I wish to surrender my license
- ☐ I wish to let my license lapse

5. DATE OF BIRTH

6. SOCIAL SECURITY NO.

7. OREGON PRACTICE COUNTY

8. SPECIALTY SECOND or SUB-SPECIALTY

9. ABMS/AOA CERTIFIED IN SPECIALTY? _____
SECOND or SUB-SPECIALTY? _____

10. IF YOU HAVE RETIRED OR MOVED YOUR PRACTICE, LIST ADDRESS & TELEPHONE NUMBER OF FORMER **OREGON** PATIENT'S RECORDS.

11. PRIMARY PRACTICE ADDRESS & PHONE NO. ON FILE WITH THE BOARD. IS THIS ADDRESS CORRECT? ☐ **YES** ☐ **NO**

IF NO, PROVIDE YOUR PRIMARY PRACTICE ADDRESS, PHONE NO. & EMAIL ADDRESS. (NO PO BOX OR PMB ADDRESSES)

Phone (____)_____
Email Address - _____

12. RESIDENCE ADDRESS ON FILE WITH THE BOARD. IS THIS ADDRESS CORRECT? ☐ **YES** ☐ **NO**

IF NO, PROVIDE YOUR RESIDENCE ADDRESS (NO PO BOX OR PMB ADDRESSES)

STAFF USE ONLY

L	N	Q	A	P	F	S	R	Opt	Tele Border	Disp Y N	Other

(RB-2009)

13. **PROVIDE THE NAME OF ALL OREGON HOSPITALS WHERE YOU HAVE STAFF PRIVILEGES.** Active or Locum Tenens physicians only.

☐ **I DO NOT HAVE HOSPITAL PRIVILEGES IN ANY OREGON HOSPITAL**

14. **CHECK ALL STATES WHERE YOU ARE CURRENTLY LICENSED:**

☐ AL	☐ AK	☐ AR	☐ AZ	☐ CA	☐ CO	☐ CT	☐ DE	☐ FL	☐ GA	☐ GU	☐ HI	☐ ID	☐ IL
☐ IN	☐ IA	☐ KS	☐ KY	☐ LA	☐ ME	☐ MD	☐ MA	☐ MI	☐ MN	☐ MS	☐ MO	☐ MT	☐ NE
☐ NV	☐ NH	☐ NJ	☐ NM	☐ NY	☐ NC	☐ ND	☐ OH	☐ OK	☐ PA	☐ PR	☐ RI	☐ SC	☐ SD
☐ TN	☐ TX	☐ UT	☐ VT	☐ VA	☐ WA	☐ WV	☐ WI	☐ WY					

15. **REGISTRATION RENEWAL QUESTIONNAIRE**

Answer all the questions in both Category I and II. Category I will help the Board determine if you meet the essential eligibility requirements for registration renewal. Category II will be reviewed to help the Board determine if you are qualified to practice safely and competently, with or without reasonable modification.

NOTE: Fraud or misrepresentation in applying for or procuring a license, registration, or reactivation in Oregon are grounds for disciplinary action, including denial or revocation of license, and are reported to the National Practitioner Data Bank and/or appropriate national professional credentialing organizations.

CATEGORY I - DURING THE PERIOD OF 1/1/06 TO THE PRESENT

If you answer "yes" to questions 2-13, you must provide a complete written explanation of the event(s) or condition(s), including dates, names, addresses, circumstances, and results along with your returned application.

☐ **Y** ☐ **N** 1. **Do you dispense drugs to your patients?** Dispensing does **not** include the administration of a drug to a patient in the physician's office, nor does it include sample drugs. A dispensing physician is defined as one who purchases prescription drugs for the purpose of providing them to patients or other individuals entitled to receive them.

☐ **Y** ☐ **N** 2. **Has any state licensing board refused to license, refused to renew, denied you a license to practice, or asked you or permitted you to withdraw an application for licensure?**
If "yes," provide full details to include state/province, reasons, circumstances and any disciplinary action. Provide a copy of all documents from the board and from you.

☐ **Y** ☐ **N** 3. **Have you had any disciplinary or adverse action imposed against any professional license or certification, or were you ever denied a professional license or certification, or have you entered into any consent agreement, stipulated order or settlement with any regulatory Board or certification agency, or have you been notified of any complaints or investigations related to any license or certification?**
If "yes," and is a regulatory agency other than Oregon Board of Medical Examiners, provide agencies, states, dates and reasons/circumstances. Provide a copy of all documents from the regulatory Board and from you.

☐ **Y** ☐ **N** 4. **Have you been denied approval to prescribe controlled substances, or been charged with a violation of federal or state narcotic laws, or been asked to surrender your DEA number?**
If "yes," provide full details, including dates and reasons/circumstances, and provide a copy of documents, reports and correspondence.

☐ **Y** ☐ **N** 5. **Have you been arrested, convicted of, or pled guilty or "nolo contendere" to ANY offense in any state in the United States or any foreign country, other than minor traffic violations, or a substance use related offense which has been evaluated by the Oregon Health Professionals Program and you are in compliance with their recommendations?** Matters in which you were pardoned or diverted, or the conviction was deferred or set aside, must be disclosed. Serious traffic convictions, such as reckless driving, driving under the influence of alcohol and/or drugs, hit-and-run, evading a peace officer, driving while the license was suspended or revoked, or failure to appear, must be disclosed. This list is not all-inclusive.
If "yes," provide full details of the arrest, dates, places, and disposition of the case. Provide a certified copy of all documents (court, police/arresting agency, etc.). If documents were purged by the arresting agency and/or the court, a letter of explanation directly from these agencies is required.

☐ **Y** ☐ **N** 6. **Have you been contacted by or asked to make a response to any governmental agency in any jurisdiction regarding any criminal or civil investigation of which you are the subject, whether or not a charge, claim or filing with a court actually occurred?**
If "yes," provide full details to include the agency conducting the investigation as well as the reasons for the criminal, civil or licensing board investigation. Provide a copy of documents, reports and correspondence.

☐ Y ☐ N 7. **Are you aware of any current, proposed, impending or threatened civil or criminal action against you?** This includes whether or not a claim, charge or filing was actually made with a court.
If "yes," provide full details to include the agency/party conducting the investigation as well as the reasons for the proposed civil or criminal action. Provide a copy of documents, reports and correspondence.

☐ Y ☐ N 8. **Have you entered into any formal, informal, out-of-court or confidential settlement to deter, prevent, or settle a claim, lawsuit, letter of intent to sue, and/or criminal action?** This includes whether or not a claim, charge or filing was actually made with a court.
If "yes," provide full details to include the agency/party with which the settlement was entered as well as the reasons for and conditions of the settlement. Provide a copy of documents, reports and correspondence.

☐ Y ☐ N 9. **Has any award, settlement or payment of any kind been made by you or on your behalf to resolve a malpractice claim, even if it was not required to be reported to the National Practitioner Data Bank (NPDB); or have you been notified in any manner that any such claim is proposed, pending or threatened, whether or not a claim, charge or filing was actually made with a court?**
If "yes," provide full details to include name of patient, date(s) of incident, allegation, disposition of the case, judgment, etc. Please indicate if the case is still pending. Provide a copy of documents, reports and correspondence.

☐ Y ☐ N 10. **Have you been restricted, suspended, terminated, requested to voluntarily resign, placed on probation, counseled, received a warning, or been subject to any remedial or disciplinary action during medical school or postgraduate training?**
If "yes," provide name of the medical/osteopathic school, or training program, dates and reason/circumstances. Provide a copy of documents, reports, and correspondence.

☐ Y ☐ N 11. **Have you had privileges denied, reduced, restricted, suspended, revoked, terminated or have you been placed on probation, been subject to staff disciplinary action or non-renewal of an employment contract, or been requested to voluntarily resign or suspend your privileges while under investigation from a hospital, clinic, surgical center, or other medically related employment; or have you been notified that such action or request is pending or proposed? Have you been allowed to withdraw your staff privileges from a hospital or surgical center?**
If "yes," provide full details to include the name of the hospital, clinic, or surgical center, dates, and reason/ circumstances. Provide a copy of documents, reports and correspondence.

☐ Y ☐ N 12. **Have you interrupted the practice of your health care profession for one year or more?**

Yes, I ceased practice from _____ to _____.
I obtained _____ hours of Category I continuing medical education during this period.
If "yes," provide length of time you did not practice medicine and the reason you ceased practice, as well as your activities (medical or non-medical) for that period of time. Include the number of hours of any CME you obtained during this period of time.

☐ Y ☐ N 13. **Have you ceased the active practice of medicine in your specialty?**
If "yes," provide the length of time you ceased the practice of your specialty and the reason.

CATEGORY II - DURING THE PERIOD OF 1/1/06 TO THE PRESENT

The answers to Category II questions are exempt from public disclosure under ORS 192 505(2), the Oregon Public Records Law, unless a party seeking disclosure, by clear and convincing evidence, shows that disclosure would not be an unreasonable invasion of privacy and that the public interest requires disclosure in the particular instance. The answers to these questions may be considered by the Board and may be disclosed in any contested case hearing or appeal of a licensing decision based upon them.

If applicable, these questions should be read to include the clause, "Other than what is already known and in compliance with the recommendations of the Oregon Health Professionals Program."

"Illegal drug use" means the use of an illegally obtained controlled substance or dangerous drug; the term "illegal drug use" also means the use of a legally obtained controlled substance or dangerous drug which is not taken in accordance with the directions of the licensed health care professional who prescribed the controlled substance or dangerous drug.

☐ Y ☐ N 1. **Have you had, or do you currently have any physical, mental, or emotional condition which impaired, or does impair your ability to practice your health care profession safely and competently? Has there been any type of inquiry into your physical, mental, or emotional health?**
If "yes," provide full details and dates regarding treatment received for the condition. If any medications were prescribed, furnish the names, dosages and the dates the medications were taken. Include the names and addresses of the treating physician, psychiatrist, psychologist, social worker, clinical therapist, or counselor and dates of treatment or therapy. Request the person providing treatment send directly to the Board complete details of treatment or counseling including dates, diagnosis (if any), treatment and prognosis.

☐ Y ☐ N 2. **Have you been admitted to any hospital or other in-patient care facility for any physical, mental or emotional condition?**
If "yes," provide information as requested for Category II Question 1.

☐ Y ☐ N 3. **Have you had, or do you currently have a dependency on the use of alcohol or drugs which impaired, or does impair, your ability to practice your health care profession safely and competently?**
If "yes," provide information as requested for Category II Question 1, but for treatment for dependency.

☐ Y ☐ N 4. **Have you engaged in the excessive or habitual use of alcohol or illegal drugs, or received any in-patient therapy treatment or been hospitalized for alcoholism, or illegal drug use, or been arrested or received a citation for a DUII (Driving Under the Influence of Intoxicants) or DWI (Driving While Intoxicated)?** "Excessive" as used in this question means the use of alcohol or drugs that leads to disturbances, fights, arrest, injury, accident, illness, loss of consciousness, or other adverse consequences.
If "yes," respond the same as for Category II Question 3. If you have been arrested for a DUII or DWI, request the arresting officer's report and court documents to be sent directly to this Board.

☐ Y ☐ N 5. **Have you been the subject of any chemical substance screening test which resulted in an indication of the presence in your body of any controlled substance, any dangerous drug, or alcohol level above .08% BAC? Have you refused to submit to any such test?** This does not include those drugs taken by you as a result of a legitimate health care diagnosis, and prescribed for you in good faith by another licensed health care professional, unless the test was conducted as part of a criminal investigation, such as DUII.
If "yes," provide a full report to include Family History/Physical; Individual Assessment and Evaluation; Psychiatric Evaluation; Psychosocial Assessment; discharge Summary and Discharge Plan for Continued Care or the equivalent. Request the Police Department/Court to provide a Certified Copy (with court seal affixed) of the original charge, the judgment, the sentence and/or the dismissal order which reflect the disposition of the matter, sent directly to this Board.

☐ Y ☐ N 6. **Have you entered into a diversion program other than the Oregon Health Professionals Program for evaluation, treatment or monitoring for substance abuse or dependency, or for correction of communication or boundary issues, in lieu of or as a condition of resolving a matter before a health care program or facility, regulatory or licensing Board, or criminal or civil court; or have you been notified that such action is pending or proposed?**
If "yes," provide full details and dates to include the name and location of the diversion program, regulatory Board, healthcare program or facility, and/or court, and reasons for and results of entering the program.

15. **EVENT OF STATE EMERGENCY**

What is the best way to contact you in the event of a statewide emergency?

Check one: ☐ Fax ☐ Phone ☐ E-mail ☐ Pager

Please provide contact number or address: _____

16. **DIRECT PATIENT CARE**

Please provide the number of hours spent in direct patient care per week.

☐ 0 – 15 hours ☐ 31 – 50 hours

☐ 16 – 30 hours ☐ 51 hours or more

I certify that the information submitted by me is true, accurate, and complete to the best of my knowledge. I understand that failure to answer the questions fully and correctly may be grounds for disciplinary action by the Board (ORS 677.205).

Physician's Signature _____ **Date** _____
(Signature stamps or proxy NOT acceptable)

Credit card payment form on page 6

NAME:_____ OREGON LICENSE NO.:_____

DATE:_____

Use the space below to make the required written explanation concerning any affirmative responses to Category I & II questions. Include dates, names, addresses, circumstances, and results. Attach an additional page, if needed, with your name and date on the top.

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1500 SW First Avenue, #620
Portland, OR 97201-5847
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FAX (971) 673-2670
www.oregon.gov/omb

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Note: All payment information is confidential, Oregon Medical Board use only.

☐ Payment Enclosed ☐ Charge my Credit Card $ _____ Amount

Office Use Only

_____ Approval Date

_____ Approval Code

Telephone Sale? ☐ Yes

_____
Printed name as it appears on card

_____
Signature

_____
Billing Address as it appears on credit card

|_|_|_|_| |_|_|_|_| |_|_|_|_| |_|_|_|_| |_|_|_| |_|_|/|_|_|

Credit Card Number – VISA, MASTERCARD, OR DISCOVER | Security Code | Expiration Date