Oregon Medical Board
1500 SW 1st Ave, Suite 620 • Portland, OR 97201
(971) 673-2700 or 877-254-6263 *(toll free in Oregon)*
Web: www.oregon.gov/OMB

PHYSICIAN ASSISTANT APPLICATION INSTRUCTIONS

Applications are valid for one year from the date filed. Submit the filing fee with application form. The Board must receive all required current documentation in order to be considered for licensure. Documentation required from other sources may arrive before the application form and filing fee. Documents older than six months that reflect an on-going/current status will require resubmission in order for an application file to be granted a complete status. **Please be sure to notify the Board of any change in your address or phone number as soon as possible.**

COMPLETING THE APPLICATION FORM:

Type or print in black ink only. Answer all questions to avoid delay in processing the application. Resumes are not acceptable. If additional space is required, attach a signed and dated addendum. Estimate dates if necessary, but complete all dates in full, showing month and year, confirming employment and education dates with employers and educational institutions. The Oregon Medical Board (Board) will return the application for completion if any questions are unanswered or dates are incomplete. Read and follow all instructions thoroughly.

PAGE 1

Name: Show your full, ***legal*** name. If your name includes Jr., II, III, initial only, or no middle name, please indicate this on the application. Your complete legal name must be shown on your certificate of registration and engrossed license and all licensees must practice their profession under the that appears on their license. You will be required to verify your ***legal*** name with documentation by submitting an official birth certificate and name change documentation, if you have changed your name as listed on the birth certificate. You must be licensed only under a legally documented name.

Other Names: List all other names (first, middle, and last) that you have used since birth. A copy of any ***legal*** name change documentation is required. You must be licensed only under a legally documented name.

National Commission on Certification of Physician Assistants (NCCPA) Certification Date or Future Exam Date: Enter the date of NCCPA Certification. If you have not yet taken the certification examination, but plan to take it in the future, enter the date on which you will take the examination, or the word "pending" if not yet scheduled. Complete and send the NCCPA Certification Verification and Exam History form to the NCCPA. This form directs the NCCPA to release to the Board your exam history, scores (passed or failed), and your certification number.

Social Security Number: As part of your application for license or renewal of your registration you are required to provide your Social Security Number to the Board of Medical Examiners. This is mandatory. The authority for this requirement is ORS 25.785, ORS 305.385, 42 USC § 666(a)(13), 42 USC § 405 (c)(2)(i) and 45 CFR § 61.7 (3)(b). Failure to provide your Social Security Number will be a basis to refuse to issue or renew the license, certification or registration you seek. Your Social Security Number will remain on file with the Board and will be used for child support enforcement by Child Services Division, for tax administration and required reports to the National Practitioner Databank and the Healthcare Integrity and Protection Databank (NPDB-HIPDB). The Board may also use your Social Security Number for identification and investigative purposes and for the collection of delinquent fines assessed by the Board.

Home & Practice Address/Phone: Provide your COMPLETE home address and practice address (if applicable) and indicate which address you would like the Board to use as your mailing address. Also, include your home and daytime telephone numbers so that Board staff can call you if necessary.

E-mail address: Provide your e-mail address if you wish to receive e-mail communications on the status of your application as it progresses through the application process. Please be aware that e-mail is not a secure medium of communication and that e-mail may contain confidential (personal) information.

Physician Assistant (PA) Training Program/Diploma Date: Provide the name, city, and state of the PA training program from which you graduated. Also, provide the graduation date as shown on your diploma.

Military Service: If you have served in the Armed Forces of the United States, list the branch of the military you served in and the dates of service.

PAGE 2 & 3

Health Related Licenses: List all health related licenses and/or certificates that you have applied for (granted or denied), still possess, or have had in the past. Regulatory agencies and/or boards must send verification ***directly*** to the Board; a faxed verification is not acceptable. In order to expedite verification to the Board contact the agencies and/or boards to determine if a fee is required prior to requesting verification of licensure.

Education, Employment, & Other Activities: List your activities for the past ten years. If you were unemployed, traveling, or moving during a particular period, list this as an activity with your location at the time. Due to the variety of activities an applicant may perform at one time, overlapping dates for activities are expected. Do not leave any gaps longer than one month. Fill in the month and year as closely as you can recall, confirming dates with employers and educational institutions. ***Dates must be complete or the application will be returned***.

PAGE 4 & 5

PERSONAL HISTORY QUESTIONS: If you answer any of the questions "yes," furnish ***thorough*** *(who, what, when, where, why, and how)* details on page 5. Attach an addendum if necessary, signed and dated. Failure to provide ***all*** details will delay the processing of your file. Third parties must send documentation ***directly*** to the Board.

CATEGORY I

Question 1

Applicant to provide full details to include state/province, reasons/circumstances, and possible disciplinary action.
Licensing Board to provide full details, and include copies of any legal documents.

Question 2

Applicant to provide full details to include state/province, type of examination failed, and dates and grades (if known) for each failure.

Question 3, 4, and 5

Applicant to provide states, dates, and reasons/circumstances.
Licensing Board to provide full details including reasons and include copies of any legal documents.

Question 6

Applicant to provide full details including dates and reasons.
State Narcotic Office/Drug Enforcement Administration (DEA) to provide full details and include copies of any legal documents.

Question 7

Applicant to provide full details of the arrest, the dates, places, and disposition of the case.
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 or other such documents which reflect the disposition of the matter.

Question 8

Applicant to provide full details to include the agency conducting the investigation as well as the reasons for the criminal or civil investigation. Provide a copy of documents, reports and correspondence.
Investigating Agency to provide full details concerning to reasons for the investigation.

Question 9

Applicant to provide full details to include details of the case, where/when incident occurred, disposition of the case, judgment, etc. Please indicate if the case is still pending. Provide a copy of the documents, reports and correspondence.

Court to provide full details concerning reasons for the investigation.

Question 10

Applicant to 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 the documents, reports and correspondence.

Agency/Party to provide full details concerning the circumstances, results, and copies of any legal documents.

Question 11

Applicant to provide full details to include name of patient, where/when incident occurred, disposition of the case, judgment, etc. Please indicate if the case is still pending. Provide a copy of documents, reports and correspondence. In most cases, the applicant's written explanation of the situation is all that is required. However, in some cases the Board will request that the applicant request information directly from the source.

Malpractice Carrier/Court may be requested to provide documentation of the claim, case, judgment, etc.

Question 12

Applicant to provide the length of time you did not practice health care profession and the reason why, as well as your activities, **(medical, or non-medical)** for that period of time.

Question 13

Applicant to provide name of the training program, dates and reasons/circumstances.

Hospital/School/Training Program to provide full details concerning the circumstances, results, and copies of any legal documents.

Question 14

Applicant to provide full details to include the name of the hospital, clinic, surgical center, dates, and reasons/circumstances.

Hospital/Employment to provide full details including dates, circumstances, results, and copies of any legal documents**.**

CATEGORY II

Question 1

Applicant to provide full details and dates regarding this treatment. If any medications were prescribed, furnish the names, dosages and the dates the medications taken. Include the names and addresses of the treating psychiatrist, psychologist, social worker, clinical therapist, or counselor and dates of treatment or therapy.

Treatment Provider to 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, and send letters and/or reports directly to this Board.

Question 2

Applicant to provide full diagnosis, details, and dates regarding this treatment. If any medications were prescribed, furnish the names, dosages, and the dates the medications were taken. Include the names and addresses of the treating psychiatrist, psychologist, social worker, clinical therapist, or counselor and dates of treatment or therapy.

Treatment Provider to provide complete details of treatment or counseling, including dates, diagnosis, treatment and prognosis. Request the appropriate official at the hospital to 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, and send all letters and/or reports directly to this Board.

Question 3

Applicant to provide full details and dates regarding this treatment. Include the names and addresses of the treating psychiatrist, psychologist, social worker, clinical therapist, or counselor and dates of treatment or therapy.

Treatment Provider to provide complete details of treatment or counseling, including dates diagnosis, treatment, and prognosis. Request the appropriate official at the hospital to 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, and send all letters and/or reports directly to this Board.

Question 4

Applicant to provide full details and dates regarding this treatment and/or hospitalization. Include the names and addresses of the treating psychiatrist, psychologist, social worker, clinical therapist, or counselor and dates of treatment or therapy.

Treatment Provider to 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, and send all letters and/or reports directly to this Board.

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 or other such documents which reflect the disposition of the matter. Letters/reports to be sent directly to this Board.

Question 5

Applicant If you received treatment related to this chemical substance screening test, provide full details and dates regarding treatment. Include names and addresses of the treating psychiatrist, psychologist, social worker, clinical therapist, or counselor and dates of treatment or therapy.

Source to provide complete details of treatment or counseling including dates, diagnosis, treatment and prognosis; all letters and/or reports to be sent directly to this Board. Hospital report must include Family History, Physical, Individual Assessment, and Evaluation, Psychiatric Evaluation, Psychosocial Assessment, Discharge Summary and Discharge Plan for Continued Care or the equivalent.

Question 6

Applicant to 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.

Source to provide treatment records and any court/legal documents directly to the Board.

PAGE 6

Identification Information: Fill in the identification information on the top left side of the page. Please read, print and sign your name in the section Release/Affidavit of Applicant and have it notarized.

Photograph: Staple a color 2" x 2" passport photograph taken, signed, and dated with date taken (within 90 days of application submission) in the space indicated. Instant Polaroid snapshots with thick backing and computer-scanned photos are NOT acceptable. The signature and date on the photograph must be on the ***front of the photograph and must not cover your face.***

DOCUMENTS SUBMITTED BY THE APPLICANT - *FAXED DOCUMENTS ARE NOT ACCEPTED*:

As a permanent part of your application file, the Board will retain all documents and photographs. DO NOT send original documents - photocopies are acceptable unless otherwise stated. Copies must be legible. All documents must be no larger than 8 ½ x 11 inches. If your originals are too large, you must have the copies reduced to the correct size.

- **Physician Assistant Diploma:**
  Submit a ***photocopy*** of your diploma from an accredited PA training program.

- **Birth Certificate:**
  Provide a ***photocopy*** of your official birth certificate issued by the state or country in which you were born. A hospital birth certificate is not acceptable. If your birth certificate is in a language other than English, provide a word-for-word notarized English translation. The following are acceptable translators:
  - An employee of a professional translating company
  - A member of the American Translators Association
  - A faculty member of the modern languages or linguistic department of a United States college or university

  The translation must be on official letterhead, and bear the translator's certification seal. **NOTE: The Board will not return translations to the applicant**. All information appearing on the document must also appear on the translation each time it appears on the original document. This includes pre-printed information, such as the letterhead of a university, titles, etc. The translation must be attached to the copy of the document being translated.

  - **Naturalization Affidavit Form:**
    Required if applicant is born in country other than the United States, is a naturalized citizen and does not have a birth certificate. Since it is a violation of law to copy a naturalization document, the Board will mail you a Naturalization Affidavit form after the submission of your application. Please follow the instructions on the Affidavit thoroughly. Again, please do not submit a copy of your naturalization document(s).

- **Name Change Documentation:** If you have been legally known by names other than that exactly listed on your birth certificate, a copy of name change documentation is required (marriage certificate, divorce decree with marriage certificate, naturalization affidavit, or court order). Copies of driver's license, social security card, passport, etc., will not be accepted as documentation of a legal name change. **IF IN A LANGUAGE OTHER THAN ENGLISH, THE BOARD REQUIRES AN OFFICIAL, WORD-FOR-WORD TRANSLATION.**

  - **Naturalization Affidavit Form:**
    Required if applicant is born in country other than the United States and has had a name change through naturalization. Since it is a violation of law to copy a naturalization document, the Board will mail you a Naturalization Affidavit form after the submission of your application. Please follow the instructions on the Affidavit thoroughly. Again, please do not submit a copy of your naturalization document(s).

- **Fingerprint Identification Verification: Fingerprint Cards**

  Pursuant to ORS 677.265 (9), applicants for licensure by the Oregon Medical Board must provide fingerprints as set forth in the above mentioned statute in order for the Board to conduct a state and federal criminal history record check. All fingerprints are processed through the Oregon State Police (OSP) and the FBI. Fingerprints must be submitted on form FD-258, which will be mailed to applicants upon receipt of application, or can be obtained from local law enforcement offices.

  Fingerprint cards must be completed properly (example), with all of the identification information filled out according to the instructions. The applicant must sign the card in the presence of the official taking the prints, who will also signed the card. In addition, the official taking the prints must complete an Identification Verification Form verifying the identity of the applicant at the time of printing. Fingerprint cards returned to the Board without this form will be rejected and applicants will be required to submit new prints – this will delay licensure. Applicants will be required to show picture identification (i.e., driver's license, state issued identification care, military identification care, passport) at the time of fingerprinting.

  Completed fingerprint cards are to be returned to the Oregon Medical Board along with the Identification Verification Form. Do not send the fingerprint cards directly to the FBI or OSP.

  The prints themselves must be of a quality meeting FBI standards, which are printed on the back of each fingerprint card. If the instructions are not followed, or the fingerprints do not meet FBI standards, the cards may be rejected by the Oregon Medical Board, OSP, or FBI. Rejected cards are sent back to the applicant with new cards for resubmission. This will delay the application process. All applicants are therefore urged to complete this step of the application process early so as not to delay licensure.

  Fingerprinting services are available from local law enforcement agencies and can be found under fingerprinting services in the yellow pages. Fees for fingerprinting services may vary.

  Questions regarding this procedure can be submitted by e-mail to the Licensing Department at bme.fingerprints@state.or.us.

- **NCCPA Certification Verification and Exam History form:**
  Complete the top section with your name, social security number and date of birth. Mail the form directly to the NCCPA at the address listed on the form. The NCCPA will then provide the Board with written confirmation of your exam history, scores (passed or failed), certificate number and current certification status with the NCCPA. If you have not yet taken the NCCPA examination and you have completed all other requirements of the PA application, you are eligible for a Limited License, Postgraduate (see document entitled PA Licensure Overview on our website). Please note that you must take the NCCPA examination within one year from the issuance of the Limited License, Postgraduate.

- **Medical Practice Act and Administrative Rules Examination:**
  This open book examination pertains to the Oregon laws and administrative rules regarding physician assistants. Board staff will notify you if you answer five or more questions incorrectly; in that case, you will have to resubmit the questionnaire. Applicant must pass the questionnaire in no more than three attempts.

- **National Practitioner Data Bank and Healthcare Integrity and Protection Data Bank self-query reports (originals):**
  If you have practiced as a physician assistant in another state, you are required to submit ***original*** self-query report***s in their entirety*** to the Board. Access the National Practitioner Data Bank (NPDB) and Healthcare Integrity and Protection Data Bank (HIPDB) website at ***http://www.npdb-hipdb.hrsa.gov/welcomesq.html*** and complete the on-line application for the individual self-query request, which you will submit to the Data Banks. When you receive the NPDB and HIPDB reports in response to your self-query request, send all the pages (the NPDB and HIPDB reports look very similar) directly to the Oregon Medical Board. Do not photocopy the reports and mail the photocopies to the Board. Do not keep one report thinking that it is a duplicate of the other; they are actually two reports.

- **Practice Description (original):**
  The Practice Description defines your scope of practice under the supervision of an actively Oregon licensed physician. You and your physician must sign and have the document notarized. This form is available from the Board's web site at ***http://www.oregon.gov/OMB/PAApplicationPacket/PracticeDescripFillin.pdf.***

DOCUMENTS MAILED DIRECTLY TO THE BOARD FROM THE SOURCE - *FAXED DOCUMENTS ARE NOT ACCEPTED FROM THE SOURCE – COPIES ARE NOT ACCEPTED:*

NOTE: If it appears that documentation was mailed by the applicant, the Board will not accept it. The following documents must be mailed directly to the Board from the reporting source. It is prudent NOT to provide a self-addressed envelope to the entity of whom you are requesting the information.

Documents from the source may be submitted to the Board prior to the application and fee, but their receipt will not be acknowledged until application and fee are submitted.

- **Verification of Education:**
  A Verification of Education Form must be filled out by the dean, administrator, or program director of your PA program showing the beginning and ending dates of your attendance, date of graduation (month, day, and year), and a statement about your educational performance. The Board will return all incomplete forms to the PA program that are not completely filled out. The Board will not accept verification of education if it is received prior to your graduation. If it appears that a verification form came from you or that you have written in the bottom portion of the form, the Board will not accept the form. Use the Verification of Education Form found on the following web page: http://www.oregon.gov/OMB/PDFforms/VerifyEducation.pdf to request this information from your educational institution.

- **Licensure Verification:**
  Send a Verification of Health Related License Form to each state licensing Board or agency where you are or were licensed or registered (active or inactive) as a Physician Assistant or ***any other health related profession***. Other regulatory agencies do not have to use this Board's form. Verification can also be in the form of a letter (on formal letterhead or computer generated), but it must show your license number, date issued, disciplinary action (currently pending issues or previous action), and current license status with the Board. A form designed for this purpose can be found at the following link: http://www.oregon.gov/OMB/PAApplicationPacket/HealthRelatedVerFillin.pdf.

- **Employment Verification:**
  Send the Verification of Health Related Employment Form to each place of employment where you practiced as a PA or any other health related profession (including non-clinical work) during the last five (5) years. Submit (fax or mail) the form to your employers with the top portion filled out by you. The Director of Personnel, administrator, other

employment official, or supervising physician will complete the bottom portion of the form. The form must include complete beginning and ending dates of employment (month, day, and year), and include an evaluation of overall performance. The employer must mail the completed form directly to the Board of Medical Examiners. If it appears that a verification form came from you or that you have written in the bottom portion of the form, the Board will not accept the form If military service included health related duties (PA, Corpsman, nurse, etc.) verification of employment is required. The Board does not accept the DD214 in lieu of verification of employment. Verifications of employment/practice from where you are currently employed or practicing that are dated more than six months prior to the receipt of your application by the Board must be re-submitted with a current verification. A form designed for this purpose can be found at the following link: http://www.oregon.gov/OMB/PDFforms/EmploymentVerFillin.pdf.

- **Federation of State Medical Boards disciplinary search – required if licensed as a PA in another state:** Send the Request for Disciplinary Inquires form to the Federation of State Medical Boards. The Federation will conduct a disciplinary search and submit the results directly to the Board of Medical Examiners. This report is required for all MD, DO, and PA applicants. A form designed for this purpose can be found at the following link: http://www.oregon.gov/OMB/PAApplicationPacket/FedDispReqFillin.pdf.

APPLICATION COMPLETION CHECKLIST

Delays in the application process are usually due to incomplete or inaccurate information; therefore, the Board encourages you to read and understand the attached instructions as well as the PA Licensure Overview. **You may not begin practice until you receive a license**. Please contact the Licensing Call Center at (971) 673-2700 if you have any questions.

FAXES ARE NOT ACCEPTED.

DOCUMENTS REQUIRED FOR APPLICATION COMPLETION:

- ❑ Completed, notarized application form, including passport photograph signed and dated on the front of the photo (do not sign over your face) and attached to the appropriate place on the application
- ❑ Initial application filing fee of $245.00
- ❑ A photocopy of your official birth certificate (hospital birth certificates are not accepted)
- ❑ Name change documentation (if applicable)
- ❑ Fingerprint Card **and** Identification Verification Form
- ❑ A photocopy of your PA program diploma
- ❑ Medical Practice Act and Administrative Rules Examination
- ❑ Verification of NCCPA Certification form
- ❑ National Practitioner Data Bank **and** Healthcare Integrity and Protection Data Bank self-query reports (if applicable)
- ❑ Practice Description notarized and signed by the applicant & supervising physician obtained from the Board's website: http://www.oregon.gov/OMB/PAApplicationPacket/PracticeDescripFillin.pdf.
- ❑ Any additional documentation the board may request

Documents sent *DIRECTLY* to the Board *from the source* for file completion:

- ❑ NCCPA verification of exam score(s) –Limited License, Postgraduate licensees have one year in which to take and pass the NCCPA exam
- ❑ Verification of Education form from your PA program
- ❑ Verification of health related employment for the last five (5) years (if applicable)
- ❑ Verification of licensure (current or previous) for health related professions (if applicable)
- ❑ Disciplinary search report from the Federation of State Medical Boards (if applicable)

RETAIN A COPY OF YOUR COMPLETED APPLICATION FOR YOUR FILES.

Please contact the Board if you have any questions or a change in address or phone number.

OREGON MEDICAL BOARD
1500 SW 1st Ave, Suite 620 • Portland, OR 97201
(971) 673-2700 or (877) 254-6263 *(toll free in Oregon)*
Web site address: www.oregon.gov/omb

Above Space for Official Use Only
Key Code 1270
$245

APPLICATION FOR LICENSURE AS A PHYSICIAN ASSISTANT IN THE STATE OF OREGON

1. Applications are valid for one year from the date filed. Submit this application with the $245 filing fee (fee for applying only; additional fees for licensure will be due upon approval of your application). **FEES ARE NON-REFUNDABLE.** Make check payable to the "Oregon Medical Board" or complete the credit card information on page 7.

2. Upon completion of your application file and if you are eligible, you will receive written notification of your file's complete status with license registration paperwork. You may not register for licensure until you have completed the application process.

3. Read the attached instructions and application carefully. Answer ALL questions completely. Attach a separate typed sheet marked as an "Addendum to Application" and sign it, if needed.

4. If your application requires special review and final Board approval prior to licensure (please see *Licensure Overview*), the following deadlines will apply to you:
   - o Application Filing Deadline: October 31, 2008
   - o File Completion Deadline: November 14, 2008
   - o Next Physician Assistant Advisory Committee Meeting: December 11, 2008
   - o Next Oregon Medical Board Meeting: January 9, 2009

As part of your application for license or renewal of your registration you are required to provide your **Social Security Number** to the Oregon Medical Board. This is mandatory. The authority for this requirement is ORS 25.785, ORS 305.385, 42 USC § 666(a)(13), 42 USC § 405 (c)(2)(i) and 45 CFR § 61.7 (3)(b). Failure to provide your Social Security Number will be a basis to refuse to issue or renew the license, certification or registration you seek. Your Social Security Number will remain on file with the Board and will be used for child support enforcement by Child Services Division, for tax administration and required reports to the National Practitioner Databank and the Healthcare Integrity and Protection Databank (NPDB-HIPDB). The Board may also use your Social Security Number for identification and investigative purposes and for the collection of delinquent fines assessed by the Board.

FULL LEGAL NAME (*last, first, middle)*		
OTHER NAMES YOU HAVE BEEN KNOWN BY		SOCIAL SECURITY NUMBER
HOME ADDRESS (Mailing Address) Street: City, State, Zip		HOME TELEPHONE
PRACTICE ADDRESS (if currently practicing as a licensed PA) Street: City, State, Zip		BUSINESS TELEPHONE
E-MAIL ADDRESS		
PHYSICIAN ASSISTANT TRAINING PROGRAM Name: City and State:		DIPLOMA DATE (Month, day, year)
NCCPA CERT. DATE **OR** FUTURE EXAM DATE	NCCPA NUMBER	CURRENT/PREVIOUS BRANCH OF MILITARY *branch:* *from:* *to:*

LIST ALL HEALTH RELATED LICENSES/CERTIFICATES YOU HAVE APPLIED FOR, HAD, OR STILL HAVE:

Type of License	State	Granted	Denied	Date Issued	Number	Current Yes	Current No

EDUCATION, EMPLOYMENT, AND OTHER ACTIVITIES FOR THE PAST TEN YEARS

List all activities for the past ten years (employment, school, vacation, unemployment, moving, etc.). **DO NOT leave a gap of more than one month** or you will be asked to provide written clarification. **Dates must be complete (month and year) or the application will be returned**. Employment verification is required for all health-related employment for the past five (5) years. Resumes are not accepted. Faxed verifications are not accepted.

Name & Mailing Address of Employer or School and/or Description of Activity (e.g., student, vacation, unemployed, traveling)	**Your Title**	**From** (Month Year)	**To** (Month Year)

Additional space on next page

EDUCATION, EMPLOYMENT, AND OTHER ACTIVITIES FOR THE PAST TEN YEARS
continued

Name & Mailing Address of Employer or School and/or Description of Activity (e.g., student, vacation, unemployed, traveling)	**Your Title**	**From** (Month Year)	**To** (Month Year)

PERSONAL HISTORY QUESTIONS

Review the Physician Assistant Application Instructions when completing this section.

The answers to some of these questions may be 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.

Answer all questions. If you answer "yes" to any of the questions, you must provide a complete explanation of the event(s) or condition(s), including dates, names, addresses, circumstances, and results. Attach a written explanation or enter a written explanation in the "Comments" section on page 5.

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

CATEGORY I

YES	NO	
☐	☐	1. Have you ever engaged in the unlicensed practice of any health care profession when you were required by law to have a license?
☐	☐	2. Have you ever failed a state or national examination or any portion of an examination to qualify for a state license to practice a health care profession?
☐	☐	3. Have you ever been asked to and/or permitted to withdraw an application for licensure, for credentialing, or for certification with any board, agency or institution?
☐	☐	4. Has any state licensing board refused to issue, refused to renew, or denied you a license to practice?
☐	☐	5. Have you ever 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 ever been notified of any complaints or investigations related to any license or certification?
☐	☐	6. Have you ever 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?
☐	☐	7. Have you ever 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?
☐	☐	8. Have you ever 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?
☐	☐	9. 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*.
☐	☐	10. Have you ever 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.*
☐	☐	11. Has any award, settlement or payment of any kind ever 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 ever 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?
☐	☐	12. Have you interrupted the practice of your health care profession for one year or more, or ceased the practice of your specialty?

☐ ☐ 13. Have you ever been restricted, suspended, terminated, requested to voluntarily resign, placed on probation, received a warning or been subject to any disciplinary action during a medically related training program?

☐ ☐ 14. Have you ever 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 ever been notified that such action or request is pending or proposed? Have you been allowed to withdraw your staff privileges from a hospital or sugical center?

Category II

"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.

YES **NO**

☐ ☐ 1. Do you currently, or have you had within the past 5 years, 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 within the past 5 years?

☐ ☐ 2. Within the past 5 years, have you been admitted to any hospital or other in-patient care facility for any physical, mental, or emotional condition?

☐ ☐ 3. Do you currently have, or have you had within the past 5 years, 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?

☐ ☐ 4. Within the past 5 years, 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 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.*

☐ ☐ 5. Within the past 5 years, 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.*

☐ ☐ 6. Within the past five years, have you entered into a diversion 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?

Comments: (Attach separate sheet(s) of paper as needed.)

IDENTIFICATION

SIGN AND DATE FRONT OF PHOTO
ATTACH PHOTO HERE

Gender: _____

Height: (ft. & in.) _____

Weight: (lbs.) _____

Hair Color: _____

Eye Color: _____

Date of Birth: _____
(*Month)* *(Day)* *(Year)*

Place of Birth: _____
(*City)* *(State)* *(Country)*

Photograph must be a 2" x 2" original passport photo, taken within 90 days of application, signed in ink showing date taken on front side. Instant Polaroid snapshots with thick backing are NOT acceptable. Computer scanned photos are NOT acceptable.

RELEASE/AFFIDAVIT OF APPLICANT

I, _____, being first duly sworn, depose and say that I am
(Applicant, TYPE or PRINT full legal name)
the person above described and identified; that I have not engaged in any of the acts prohibited by the statutes of the state of Oregon, particularly those acts set forth in Sections ORS 677.080 or 677.190.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates, business associations (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign), which includes state medical licensing boards, and the Federation of State Medical Boards, to release to this licensing board any information, files or records requested by this board in connection with the processing of this application. I further authorize this board to release to the organizations, individuals and groups listed above any information which is material to my application or pertinent to my practice of medicine during the processing of this application and the time that I am a licensee of this board.

I have read carefully the questions in the foregoing application and I have answered them completely, without reservation of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act is grounds for the denial, suspension or revocation of my license to practice medicine in the state of Oregon.

_____
Signature of Applicant *(to be signed in the presence of Notary Public)*

Portion below to be completed by notary

Subscribed and sworn to before me on _____

Notary Signature _____

Notary Public for _____ Commission expires _____

Notary Seal or Imprint

KEEP A COPY OF THIS APPLICATION FOR YOUR RECORDS

FAXED APPLICATIONS NOT ACCEPTED

OREGON MEDICAL BOARD
1500 SW First Avenue, Suite 620
Portland, OR 97201-5847
Phone (971) 673-2700
FAX (971) 673-2670
www.oregon.gov/omb

Credit Card Payment

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

Company Name

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Amount

Printed name as it appears on card

Signature

Phone Number with Area Code

Cardholder's Mailing Address

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