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

INSTRUCTIONS TO COMPLETE AFFIDAVIT FOR REACTIVATION OF OREGON MEDICAL LICENSE

If you wish to return to Oregon to practice or wish to practice under a status where you can receive remuneration for your services, you are required to reactivate your Inactive, Locum Tenens, Active – Military/Public Health, Active – Teleradiology, Active – Telemonitoring, Emeritus, or Emeritus Inactive status to an Active, Locum Tenens, or Emeritus Active status. Enclosed are the instructions, the affidavit and other forms needed to complete the reactivation process.

Please read the following instructions carefully as omissions or incorrect information will delay the processing of the affidavit which will delay the beginning date of your practice in Oregon.

WHY IS IT NECESSARY TO COMPLETE AN AFFIDAVIT TO REACTIVATE MY LICENSE?

Since the Board is charged with the responsibility of protecting the public, prior to allowing a licensee to begin practice (if never worked in Oregon after licensure) or to resume practice in the state, this Board must be assured that there is no information of a derogatory or questionable nature in the licensee's background prior to granting reactivation.

HOW LONG DOES IT TAKE TO REACTIVATE MY LICENSE?

You are advised to submit your affidavit a minimum of two months prior to the date you wish to change your status. This will allow time for Board staff to complete processing as well as to receive the required items to be submitted from other sources. Barring need for review by the **Administrative Affairs Committee** of the Board, your license will be reactivated when your file is complete.

If you have answered "Yes" to any of the Personal History Questions on the affidavit (with the exception of Category 1 Questions 1, 2 and perhaps 11), **or** if the Board receives derogatory information or information that is of concern to the Board, it may be necessary that your affidavit be presented to the Administrative Affairs Committee (AAC). This committee meets each March, June, September and December.

In order to present information to the Administrative Affairs Committee, your affidavit must be totally complete at least one month prior to that meeting. Incomplete files will not be presented to the Committee and if not complete for one Committee meeting will be rescheduled for the next quarterly Committee meeting. Review of your affidavit by the AAC will delay the reactivation process and would mean that you would need to delay your practice plans in the state of Oregon.

Once the AAC has reviewed your file, the Committee will make a recommendation to the full Board. The full Board meets each **JANUARY, APRIL, JULY and OCTOBER**. You will be advised of the Board's decision after the meeting**.**

FEES TO REACTIVATE

All licensees who wish to reactivate their license are required to pay certain fees to complete this process. The Affidavit of Reactivation application fee is $50.00. If you have renewed your license every biennium, you probably will not owe any back license renewal fees nor a late fee. However, if a licensee's license is currently on **Lapsed** status due to failure to pay license renewal fees for previous years, these fees must be paid plus a late fee of $150.00 as a part of the reactivation process.

- You may contact Board staff (dee.hudnall@state.or.us) or (971) 673-2700 to determine whether you owe any additional license renewal fees and to have staff look up the date you last had Active status. This is needed for you to complete the chronology, employment verification, and licenses practiced under, applied for or granted sections of the Affidavit.

OR

- You may submit the completed form and $50.00 affidavit fee to the Board and staff will determine if any additional license renewal fees are owed. You will be informed if any additional fees are owed prior to the Board processing your Affidavit of Reactivation. If you have renewed your license every biennium, you probably will not owe any back license renewal fees nor a late fee.

Please complete the Application for Registration: Reactivating MD/DO/DPM form and submit with any license renewal fees that you may owe. This form and Instructions to filling out this form are at the end of the Affidavit of Reactivation packet. Even if you do not owe any past license renewal fees, you must complete this form with your Oregon practice/residence address and practice status in Oregon (Active, Inactive, Locum Tenens, Emeritus, etc.)

Fees may be paid by personal check, or credit card (VISA, MASTERCARD, DISCOVER card only).

HOW TO FILL OUT THE AFFIDAVIT

The affidavit must be complete and all information requested must be provided. On the affidavit you are asked to provide information for a specific period of time, identified as Date Last ACTIVE or 5 years ago (whichever is most recent).

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 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.

Personal History Questions
If you answered "YES" to any of the Personal History questions**,** you must provide full details to include names, addresses, dates, circumstances, results, etc., and request that the appropriate official or source entity send a letter of explanation directly to the Board. This letter or documentation should be accompanied by legal documents, hospital admitting information, discharge summary, or psychiatric report where appropriate. Failure to provide all details will delay the processing of your file.

CATEGORY I

Question 1	
Applicant	Provide full details to include date of licensure, license number, type of license, and current status of the license.
Licensing Board	Provide verification of licensure to include license number, date issued, current status.
Question 2	
Applicant	Provide full details to include state/province, type of examination failed, and dates and grades (if known) for each failure.
Examination Agency	The report of examination grades will verify any failed attempts.
Question 3	
Applicant	Provide full details to include state/province, reasons/circumstances and any disciplinary action.
Licensing Board	Provide full details and include copies of any legal documents.
Questions 4 and 5	
Applicant	Provide states, dates and reasons/circumstances.
Licensing Board	Provide full details and include copies of any legal documents.
Question 6	
Applicant	Provide full details including dates and reasons/circumstances, and provide a copy of documents, reports and correspondence.
State Narcotic Office/Drug Enforcement Administration (DEA)	Provide full details and include copies of any legal documents.

Question 7	
Applicant	Provide full details of the arrest, the dates, places, and disposition of the case.
Police Department/ Court	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	Provide full details to include the agency conducting the investigation as well as the reasons for the criminal, civil, or licensing investigation. Provide a copy of documents, reports and correspondence.
Investigating Agency	Provide full details concerning reasons for the investigation.
Question 9	
Applicant	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	Provide full details concerning reasons for the investigation.
Question 10	
Applicant	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	In some cases information is needed in addition to the applicant's explanation (see below).
Question 11	
Applicant	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 the documents, reports and correspondence.
Malpractice Carrier/Court	In some cases information is needed in addition to the applicant's explanation. (see above)
Question 12	
Applicant	Provide the length of time you did not practice medicine or ceased the practice of your specialty and the reason why, as well as your activities, **(medical or non-medical)** for that period of time.
Hospital/School/ Training Program	In most cases, the applicant's explanation is all that is needed concerning an affirmative response to question 12. However, in some cases the applicant will be asked to request information be sent directly from other sources to the Board.
Question 13	
Applicant	Provide name of the medical/osteopathic/podiatric school, training program, dates and reasons/circumstances.
School/ Training Program	Provide full details concerning the circumstances, results, and copies of any legal documents.
Question 14	
Applicant	Provide full details to include the name of the hospital, clinic, surgical center, dates, and reasons/circumstances.
Hospital/Employment	Provide full details, including dates, circumstances, results, and copies of any legal documents.

CATEGORY II

Question 1	
Applicant	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 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.
Source	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. Letters/reports to be sent directly to this Board.
Question 2	
Applicant	Provide full 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. Request the person providing treatment send directly to the Board complete details of treatment or counseling including dates, diagnosis (if any), treatment and prognosis.
Source	Treatment provider to furnish complete details of treatment or counseling Including dates, diagnosis (if any), treatment and prognosis. Request the Appropriate official at the hospital send directly to the Board 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. Letters/reports need to be sent directly to this Board.
Question 3	
Applicant	If you received treatment for this dependency, 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. Request the person providing treatment send directly to the Board complete details of treatment or counseling including dates, diagnosis (if any), treatment and prognosis.
Source	Treatment provider to furnish complete details of treatment or counseling Including dates, diagnosis (if any), treatment, and prognosis. Request the appropriate official at the hospital send directly to the Board 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. Letters/reports to be sent directly to this Board.
Question 4	
Applicant	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. Request the person providing treatment send directly to the Board complete details of treatment or counseling including dates, diagnosis (if any), treatment and prognosis. If you have been arrested for a DUII or DWI, request for the arresting officer's report and court documents to be sent directly to this Board.
Source	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. **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. Request the person providing treatment send directly to the Board complete details of treatment or counseling including dates, diagnosis (if any), treatment and prognosis.
Source	Furnish complete details of treatment or counseling including dates, Diagnosis (if any), treatment and prognosis. Hospital report is also needed to include Family History, Physical, Individual Assessment and

	Evaluation, Psychiatric Evaluation, Psychosocial Assessment, Discharge Summary and Discharge Plan for Continued Care or the equivalent**.** Letters/reports to be sent directly to this Board.
Question 6	
Applicant	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	Furnish treatment records and any court/legal documents directly to the Board.

Photograph: Attach photograph in this space by stapling it to the application. Photograph should be an original of passport quality, a close-up front view of head and shoulders (not a profile). Photograph must be taken within 90 days prior to submitting your affidavit, signed in ink on the front, showing date taken. Photograph may not be computer generated or scanned.

Oregon Location for Practice
Indicate your anticipated Oregon location (clinic, hospital, group, etc. and city), date to begin practice or hospital where training is to be completed on the affidavit where indicated.

Release/Affidavit of Applicant: You must complete this affidavit in the presence of a Notary Public. The Notary Public must sign, date, and affix seal to the affidavit. The notarization must be placed directly on the application.

DOCUMENTS TO BE SUBMITTED BY THE LICENSEE

Fingerprint Card
Pursuant to ORS 677.265 (9), applicants for licensure by the Oregon Medical Board and licensees requesting to reactivate their license 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 the affidavit, 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 or licensee must sign the card in the presence of the official taking the prints, who will also sign 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-licensees will be required to show picture identification (i.e., driver's license, state issued identification card, military identification card, 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-reactivation process early so as not to delay licensure or reactivation.**

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 email to the Licensing Department at bme.fingerprints@state.or.us

Specialty Board Certificate or Recertification Certificate
If you were certified or recertified by a specialty board recognized by the American Board of Medical Specialties, the American Osteopathic Association's Bureau of Medical Specialists, the American Board of Podiatric Orthopedics & Primary Medicine, or the American Board of Podiatric Surgery since the time you last had Active status in Oregon or during the past 5 years, whichever is the most recent, please provide a copy of the certificate issued by the American Specialty Board in your specialty. If the certificate is not available, submit a copy of the result letter notifying you of your Diplomat or recertification status.

Letter Requesting Waiver of the Special Purpose Examination (SPEX) or Comprehensive Osteopathic Medical Variable-Purpose Examination (COMVEX)
Physician applicants (MD/DO) may be required to take the SPEX or COMVEX examination if completion of postgraduate training, Board certification or recertification was obtained 10 or more years prior to filing an application for Oregon licensure, or the applicant ceased practice for 12 or more consecutive months. These exams are given on an ongoing basis. **If an examination is required, Oregon practice would be delayed until the examination has been passed.**

If you wish to request a waiver of the SPEX or COMVEX examination, you must submit a request in writing and provide documentation of continuing medical education for the past 1-3 years, or have a letter sent directly to the Board stating you have been granted an appointment as a professor or associate professor at the Oregon Health and Science University.

Your request will be reviewed by the Board's Executive Director who may grant a waiver of the examination depending on how long you have been out of practice, or your request may be referred to the Administrative Affairs Committee (AAC) of the Board for review at their next meeting. This will require that ALL processing of your reactivation file be complete by at least one month prior to the AAC meeting. The AAC meets quarterly, each March, June, September and December. The dates of the AAC meetings can be found at http://egov.oregon.gov/BME/phyappdeadlinedates.shtml.

Further details for requesting a waiver of the SPEX can be seen at Notice to Oregon SPEX Applicants and Request for SPEX Waiver (http://egov.oregon.gov/BME/MD-DO_Application/Spex-Exam-memo.pdf).

Please be advised that if you request a waiver of the SPEX or COMVEX examination, you will not be eligible to reactivate your license until you are either granted approval of the waiver or take and pass the examination.

DPM: ORAL EXAMINATION
If a podiatric physician has ceased the active practice of podiatry for 12 or more consecutive months, an oral examination in podiatry may be required to test general podiatric knowledge**. If this examination is required, Oregon practice would be delayed until the examination could be scheduled and passed.**

DOCUMENTS REQUESTED FROM OTHER SOURCES

Each licensee who wishes to reactivate their Oregon license must request that certain information be submitted to the Board directly from the source to complete the reactivation process.

MD/DO: Disciplinary Search by the Federation of State Medical Boards (FSMB)
MD/DO licensees must either send the FSMB the Disciplinary Inquiries form that is a part of the affidavit packet or go directly to the Federation web site http://www.fsmb.org/pdf/fpdc_databank_inquiry_form.pdf and download the Board Action Data Bank Inquiry Request form, fill it out and submit it to the Federation, so that a disciplinary search can be conducted, and the results mailed to the Board. This is required of all MD/DO applicants for licensure reactivation.

DPM: Disciplinary Search by the Federation of Podiatric Medical Boards (FPMB)
DPM licensees must either send the FPMB the form that is a part of the affidavit packet, or go directly to the FPMB web site at https://www.fpmb.org/orderreports and fill in the form for a disciplinary report, pay the $50.00 fee by credit card or send the FPMB the form with a check. The results of the disciplinary inquiry are mailed to the Board. This is required of all DPM applicants for licensure reactivation.

National Practitioner Data Bank and Healthcare Integrity and Protection Data Bank
All MD/DO/DPM licensees are required to request a Self-Query from the National Practitioner Data Bank and Healthcare Integrity and Protection Data Bank and send the results to the Board. The results of the Self-Query will be mailed to you and you must forward them to the Board exactly as you received them.

Please access the National Practitioner Data Bank and Healthcare Integrity and Protection Data Bank website: http://www.npdb-hipdb.hrsa.gov. Complete the on-line application for the individual Self-Query request (http://www.npdb-hipdb.hrsa.gov/welcomesq.html) which you will submit electronically to the Data Banks. The completed form must also be printed, signed, notarized and mailed to the Data Banks with your credit card information for payment of the $16.00 fee ($8.00 per Data Bank) for the Self-Query. The Data Banks accepts credit card payment only (VISA, Mastercard, Discover card, and American Express). This is the only verification that will be accepted from the licensee, rather than directly from the source.

When you receive the Self-Query report forward both originals (NPDB and HIPDB) to the Oregon Board. The report should be current and have been completed within the past three months. If you have questions you may contact the NPDB-HIPDB at 1-800-767-6732.

State Board Letters From States Where Licensed
Each licensee must request a verification of licensure for every medical license the licensee practiced under, was granted, or applied for, directly from each medical board in the United States or Canada, since the time you last had Active status in Oregon or during the past 5 years, whichever is most recent. This letter must show the license number, date issued and current standing with the Board.

Training Verifications From Internship, Residency, Fellowship Hospitals
Each licensee must request a verification of training directly from any training program where training has been completed since the time you last had Active status in Oregon or during the past 5 years, whichever is most recent. This letter must show the type of training completed, the dates of the training as well as answers to questions regarding performance during the training program.

Employment, Staff Membership Verification
Each licensee must request a verification of employment directly from any hospital or clinic where the licensee has practiced since the time you last had Active status in Oregon or during the past 5 years, whichever is most recent. This letter must show the beginning and ending dates of employment or staff membership as well as answers to questions regarding performance during the period of employment or staff membership.

Additional Information May Be Needed to Complete Reactivation
After the affidavit has been received and reviewed, the Board may request further information, documents or letters to complete the affidavit process.

DOCTOR'S TITLE LAW

Each licensee is required to comply with the Doctor's Title Law. A copy is enclosed for your reference. Since the law relates to how you indicate your healing art; physician, surgeon, podiatrist, etc., it is suggested that you review this law prior to ordering stationery, billing forms, etc., for your Oregon practice.

ANSWERS TO FREQUENTLY ASKED QUESTIONS CONCERNING REACTIVATION

Drug Enforcement Administration (DEA)
The Oregon Board does not issue DEA registration. To obtain your **Federal DEA number**, it is suggested that you contact the DEA Field office at 400 2nd Avenue, West, Seattle, Washington 98119, (888) 219-4261, to advise that you are applying for an Oregon license. If this is your first DEA registration, request Form #224; otherwise, request a Change of Address Form. Their application becomes invalid after 40 days so do not submit your application to the DEA until 40 days prior to the date you wish to practice in the State of Oregon.

State Narcotic Registration
There is no separate state narcotic number required for the State of Oregon.

Oregon License Number
Your Oregon license number received at the time of initial licensure in the State of Oregon will remain the same after the reactivation of your license. Your license registration status will change.

Certificate of Registration
When the reactivation process has been completed, you will receive a new Certificate of Registration, which will show your new license registration status.

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

Above Space for Official Use Only

Key Code 1600

$50.00

License #	Date License Issued
Date Last ACTIVE or 5 years ago (whichever date is more recent)	
Date Reactivated	License Status ☐ ACTIVE ☐ LOCUM TENENS

SPACE ABOVE THIS LINE FOR BOARD USE ONLY

AFFIDAVIT FOR REACTIVATION OF OREGON MEDICAL LICENSE

1. **FULL LEGAL NAME** Last name (Jr., II, etc.)	First Name	Middle	☐ MD ☐ DO ☐ DPM
2. **OTHER NAMES YOU HAVE BEEN KNOWN BY:** Last Name	First Name	Middle Name	

3. **CURRENT BUSINESS STREET ADDRESS**	City	State	Zip
4. **CURRENT RESIDENCE STREET ADDRESS**	City	State	Zip
5. **CURRENT OTHER STREET ADDRESS (IF APPLICABLE)**	City	State	Zip

6. **BUSINESS TELEPHONE**	7. **RESIDENCE TELEPHONE**	8. **OTHER TELEPHONE**
9. **E-MAIL ADDRESS**	10. **SOCIAL SECURITY NUMBER**	

➔ Please indicate your mailing address: ☐ **Business** ☐ **Residence** ☐ **Other**

11. Do you want your practice address posted on the Oregon Medical Boards' web site? ☐ **Yes** ☐ **No**

12. **MEDICAL/OSTEOPATHIC/PODIATRIC SCHOOL GRADUATED School, City, State/Country**	**DEGREE (Mo/Day/Year)**	☐ **MD** ☐ **DO** ☐ **DPM**

In the section below, list all licenses you have practiced under, been granted, or applied for during the period of time identified as Date Last ACTIVE or 5 years ago (whichever is most recent). Attach a separate sheet if necessary.

13. **ALL LICENSES** (even if not current) State/province/country	RESULTS Explain Granted	Denied	Pending	LICENSE/CERTIFICATE Issued Mo.	Yr	Number	PERM or TEMP	LICENSE OBTAINED BY USMLE	FLEX	Recip	Natl Bd	CURRENT Y	N

14. **STAFF PRIVILEGES.** List ALL hospitals in which you have applied for staff privileges for practice or military service during the period of time identified as Date Last ACTIVE or 5 years ago (whichever is most recent). Do NOT include hospital training programs. Use only standard abbreviations. A curriculum vitae is NOT acceptable. Attach a separate sheet if necessary.

NAME OF HOSPITAL - Address	Granted	Explain Denied	Pending	Restricted	Hospital Usage Daily/Monthly	Dates (Mo/Yr) FROM	TO

☐ **I HAVE NEVER APPLIED FOR NOR OBTAINED STAFF PRIVILEGES IN ANY HOSPITAL.** Please explain below:

15. **CHRONOLOGY OF ACTIVITIES.** List ALL activities including training, employment, locum tenens, vacations in date order **only** during the period of time identified as Date Last ACTIVE or 5 years ago (whichever is most recent), up to and including the present date. Account for all periods of time and indicate specialty field for all training programs. Use only standard abbreviations. A curriculum vitae is NOT acceptable. Attach a separate sheet if necessary.

TYPE OF ACTIVITY (training, practice, vacation)	**TRAINING LEVELS**	**SPECIALTY**	**NAME OF INSTITUTION OR PLACE OF PRACTICE AND MAILING ADDRESS**	**BEGINNING DATE** Mo Yr	**ENDING DATE** Mo Yr
EXAMPLE Internship	PG1	Rotating	Yale Univ. Sch Med., 333 Cedar St., New Haven, CT 06520	7 97	6 98
Residency	PG 2 and 3	Internal Med	Yale Univ. Sch Med., 333 Cedar St., New Haven, CT 06520	7 98	6 00
Private Practice - Group		Internal Med	10 Oak Grove Rd, Stamford, CT 06907	7 00	11 06

LIST ALL ACTIVITIES (TRAINING, PRACTICE, VACATION BETWEEN ACTIVITIES ONLY) UP TO PRESENT DATE.

16. PERSONAL HISTORY QUESTIONS FOR REACTIVATION. 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 ay be disclosed in any contested case hearing or appeal of a licensing decision based upon them.

Answer all questions. All questions apply to the date you were last ACTIVE or 5 years ago (whichever date is more recent). If you answer "yes" to any of the questions, you must attach a complete written explanation of the event(s) or condition(s), including dates, names, addresses, circumstances, and results along with your returned application.

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. Do you hold, or have you ever held, any licenses to practice another health care profession?
☐	☐	2. Have you ever failed a licensing examination, or any portion of a licensing examination, for a medical license (USMLE, NBME, NBOME, FLEX, ECFMG) or for any other health professional license? *If you ever failed a portion of a licensing examination you must answer "yes" even if you later passed the examination.*
☐	☐	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 medical school or postgraduate training?

☐ ☐ 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 surgical 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?

WRITTEN EXPLANATION CONCERNING "YES" RESPONSES TO PERSONAL HISTORY QUESTIONS

If you answered "YES" to any personal history question please furnish a thorough explanation, including dates, names and addresses, circumstances, results, and all copies of legal documents/letters. If there is not enough space, attach a signed and dated "Addendum."

Category _____ Question # _____
Category _____ Question # _____

17. **DATE OF BIRTH (Mo/Day/Yr)**

ATTACH (STAPLE) PHOTOGRAPH HERE. SIGN YOUR NAME IN INK & SHOW DATE TAKEN ON FRONT OF PHOTOGRAPH.

18. **PLACE OF BIRTH** City, State, or Country

19. **PHYSICAL DESCRIPTION**

HEIGHT	WEIGHT	EYES	HAIR

20. **MILITARY SERVICE**

Active Duty Only

(Branch) _____ FROM **(Mo/Day/Yr)**_____
TO **(Mo/Day/Yr)**_____
(Branch) _____ FROM **(Mo/Day/Yr)**_____
TO **(Mo/Day/Yr)**_____

21. **MEDICAL SPECIALTY** Primary specialty you plan to practice in Oregon

PHOTOGRAPH MUST BE:

1. An original, passport quality photograph. No scanned or Polaroid photographs with thick backing.
2. Close-up front view of head and shoulders (not a profile).
3. No larger than 2" x 3" and no smaller than 2" x 2".
4. Taken within **90 days** prior to filing this application.
5. Signed in ink showing date taken on front of photograph.

22. **OREGON PRACTICE INFORMATION**

Hospital/Clinic/Medical group

Street address

City, state, zip

Proposed Beginning Date of Practice:_____ Dates of Locum Tenens:_____

23. **INDICATE ONE OF THE FOLLOWING:**

☐ Moving to Oregon to practice – Requires **ACTIVE** status

☐ Practicing in Oregon but residing in a border town in Idaho, California or Nevada (within 100 miles of Oregon border) – Requires **ACTIVE** status

☐ Completing Locum Tenens assignment only – Requires **LOCUM TENENS** status

☐ Completing training in Oregon

24. **AMERICAN BOARD CERTIFICATION:** Below list any certifications or recertifications you have obtained for any of the following boards:

- American Board of Medical Specialties (ABMS)
- American Osteopathic Association's Bureau of Osteopathic Specialists (AOA--BOS)
- American Board of Podiatric Orthopedics & Primary Medicine (ABPOPM)
- American Board of Podiatric Surgery (ABPS)

SPECIALTY BOARD	**CERTIFICATE NO**.	**CERTIFIED (Mo/Day/Yr)**
SPECIALTY BOARD	**CERTIFICATE NO.**	**CERTIFIED (Mo/Day/Yr)**
SPECIALTY BOARD	**CERTIFICATE NO.**	**RECERTIFIED (Mo/Day/Yr)**
SPECIALTY BOARD	**CERTIFICATE NO**.	**RECERTIFIED (Mo/Day/Yr)**

RELEASE/AFFIDAVIT OF APPLICANT FOR REACTIVATION

I, _____, being first duly sworn, depose and say that I am the person
(Applicant, **TYPE** or **PRINT** full legal name)

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/podiatry 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.

☛ _____
(Applicant to sign usual **business** signature in presence of Notary Public)

Affix a Legible Seal Here

Subscribed and sworn
to me before this _____ day of _____, 20_____

Notary signature ☛ _____

Notary Public for _____

My commission expires _____

NOTARIZE ON THIS FORM ONLY

OREGON MEDICAL BOARD
1500 SW First Avenue, Suite 620
Portland, OR 97201-5847
Phone (971) 673-2700

Credit Card Payment

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

Company Name

$ _____
Amount

Printed name as it appears on card

Signature

Phone Number with Area Code

Cardholder's Mailing Address

☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐ ☐☐-☐☐ ☐☐☐

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

REACTIVATION OF LICENSE

Applicant Name:_____

(PLEASE TYPE or PRINT LEGIBLY)

MALPRACTICE / MEDICAL PROFESSIONAL CLAIMS INFORMATION

Furnish information on separate sheet for each malpractice claim. Make copies of this form if necessary. Print or write legibly.

NAME OF PATIENT:	
DATE OF INCIDENT:	
LOCATION (HOSP, ETC.):	
ALLEGATION:	
CONDITION / DIAGNOSIS AT TIME OF INCIDENT:	
DESCRIPTION OF MEDICAL TREATMENT RENDERED:	
CONDITION OF PATIENT SUBSEQUENT TO TREATMENT:	
DISPOSITION OF CLAIM: (Include settlement amount)	
DISPOSITION BY MEDICAL BOARD IF APPLICABLE:	

APPLICANT SIGNATURE: _____ **DATE:** _____

REACTIVATION OF LICENSE

Applicant Name:_____

(PLEASE TYPE or PRINT LEGIBLY)

WRITTEN EXPLANATION OF "YES" RESPONSES TO PERSONAL HISTORY QUESTIONS

Use this form to make the required written explanation concerning any affirmative responses to personal history questions. Use reverse side to provide required addresses. Make additional copies of this form if necessary. PRINT LEGIBLY OR TYPE YOUR RESPONSE. Refer to the instructions you received with the application which show the specific information needed, such as circumstances, results, etc., concerning each affirmative response. See separate form for response to the malpractice question.

Signature:_____ **Date signed:**_____

REACTIVATION OF LICENSE

Applicant Name:_____

(PLEASE TYPE or PRINT LEGIBLY)

Use this form to list the full names, mailing addresses, phone numbers, specific dates, etc., for any person, hospital, facility, etc., related to your affirmative responses to the personal history questions.

Question # _____
Name_____
Address_____
_____
Phone Number _____ **Dates** _____
Area code

Question # _____
Name_____
Address_____
_____
Phone Number _____ **Dates** _____
Area code

Question # _____
Name_____
Address_____
_____
Phone Number _____ **Dates** _____
Area code

Question # _____
Name_____
Address_____
_____
Phone Number _____ **Dates** _____
Area code

Question # _____
Name_____
Address_____
_____
Phone Number _____ **Dates** _____
Area code

Question # _____
Name_____
Address_____
_____
Phone Number _____ **Dates** _____
Area code

REACTIVATION OF OREGON LICENSE

OREGON MEDICAL BOARD
1500 S. W. FIRST AVENUE, #620
PORTLAND, OR 97201-5847
(971) 673-2700 www.oregon.gov/omb

ATTN: MD/DO/DPM LICENSING

CHANGE OF ADDRESS FORM -- REACTIVATION OF LICENSE

- **PLEASE BE SURE TO NOTIFY THE BOARD IMMEDIATELY CONCERNING ADDRESS CHANGES SO THAT YOU WILL RECEIVE ALL INFORMATION CONCERNING THE REACTIVATION OF YOUR OREGON LICENSE.**

- **IF YOU ANTICIPATE MORE THAN ONE ADDRESS CHANGE DURING THE REACTIVATION PROCESS, PLEASE MAKE COPIES OF THIS FORM.**

PLEASE CHANGE MY ADDRESS/PHONE NUMBER AS FOLLOWS:

PRINT NAME

NEW BUSINESS ADDRESS		
CITY	**STATE**	**ZIP CODE**
NEW BUSINESS PHONE NUMBER		
EFFECTIVE DATE	☐ **USE FOR MAILING**	

NEW RESIDENCE ADDRESS		
CITY	**STATE**	**ZIP CODE**
NEW RESIDENCE PHONE NUMBER		
EFFECTIVE DATE	☐ **USE FOR MAILING**	

EMAIL ADDRESS

SIGNATURE	**DATE SIGNED**

REACTIVATION OF LICENSE

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

MD/DO/DPM LICENSURE - FAXED RESPONSES NOT ACCEPTED

VERIFICATION OF INTERNSHIP, RESIDENCY, FELLOWSHIP TRAINING

INSTRUCTIONS TO APPLICANT: Complete UPPER portion of form and mail directly to any hospital/institution where training has been served. Training hospital/institution is to complete LOWER portion of the form and return **DIRECTLY** to the OREGON BOARD.

Last Name First Name Middle Name

Other names you have been known by

Date of Birth **Social Security Number**

Hospital/Institution name at the time of training **From (mo/day/yr) To (mo/day/yr)**

I authorize the release of information, favorable or otherwise, from my postgraduate training program listed above, to the Oregon Medical Board.

☛ **Signature of Applicant** _____

INSTRUCTIONS TO PROGRAM DIRECTOR: Please complete this form, sign and return it to the Board at the above address in an institution envelope. **Please affix the seal of the hospital/institution**. If hospital/institution does not have a seal**,** please so indicate. **All applicants have signed a general release, which relieves anyone of liability for information furnished in good faith.**

Training	Postgraduate Level of Training						Specialty Dept.	FROM mo/day/yr	TO mo/day/yr
Internship	☐ PG 1	☐ PG 2	☐ PG 3	☐ PG 4	☐ PG 5	☐ PG 6			
Residency	☐ PG 1	☐ PG 2	☐ PG 3	☐ PG 4	☐ PG 5	☐ PG 6			
Residency	☐ PG 1	☐ PG 2	☐ PG 3	☐ PG 4	☐ PG 5	☐ PG 6			
Residency	☐ PG 1	☐ PG 2	☐ PG 3	☐ PG 4	☐ PG 5	☐ PG 6			
Residency	☐ PG 1	☐ PG 2	☐ PG 3	☐ PG 4	☐ PG 5	☐ PG 6			
Fellowship	☐ PG 1	☐ PG 2	☐ PG 3	☐ PG 4	☐ PG 5	☐ PG 6			

Unusual Circumstances: The following apply to unusual circumstances that occurred during any part of the applicant's training. Please circle the appropriate response. **If you answer yes to any of these questions, please enclose an explanation on Page 2 of this form, and attach copies of any documentation.**

1.	Did the applicant take any leaves of absence or breaks from his/her postgraduate training?	☐	YES	☐	NO
2.	Was the applicant ever placed on probation, disciplined, or under investigation?	☐	YES	☐	NO
3.	Were any negative reports ever filed by instructors regarding the applicant?	☐	YES	☐	NO
4.	Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence, disciplinary problems, or any other reason?	☐	YES	☐	NO
5.	Were there any concerns regarding the applicant's moral and ethical character, or use or abuse of alcohol, narcotics, barbiturates, amphetamines and/or other drugs?	☐	YES	☐	NO
6.	Were there any concerns regarding the applicant's judgment, medical knowledge, performance or emotional stability?	☐	YES	☐	NO

Affix Institutional Seal Here if Available

Program Director's Signature

Print Name Date Signed / /

Specialty Depart.

Name of Hospital

Mailing Address

City State Zip

Phone Number ( )

Use this page to provide an explanation to a "yes" response to any of the questions on page 1 of this Verification of Internship, Residency, Fellowship Training form.

1. Did the applicant take any leaves of absence or breaks from his/her postgraduate training?

2. Was the applicant ever placed on probation, disciplined, or under investigation?

3. Were any negative reports every filed by instructors regarding the applicant?

4. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence, disciplinary problems, or any other reason?

5. Were there any concerns regarding the applicant's moral and ethical character, or use or abuse of alcohol, narcotics, barbiturates, amphetamines and/or other drugs?

6. Were there any concerns regarding the applicant's judgment, medical knowledge, performance or emotional stability?

REACTIVATION OF LICENSE

OREGON MEDICAL BOARD
1500 S.W. 1st Avenue, #620, Portland, OR 97201-5847
(971) 673-2700 www.oregon.gov/omb

MD/DO/DPM LICENSURE - FAXED RESPONSES NOT ACCEPTED

VERIFICATION OF PRACTICE, EMPLOYMENT, STAFF MEMBERSHIP

INSTRUCTIONS TO APPLICANT: Applicant to complete UPPER portion of form and forward to any hospital, clinic**,** emergency room, etc., where employed or where hospital staff membership has been requested. Source is to complete LOWER portion of form and return DIRECTLY to the OREGON BOARD.

Last Name **First Name** **Middle Name** **Social Security Number**

Name of Hospital, Clinic, Facility at the time **of the association**

Dates of Association **From (mo/day/yr)** **To (mo/day/yr)**

Type of Association: ☐ **Employee** ☐ **Staff Member** ☐ **Locum Tenens** ☐ **Emergency Room** ☐ **Instructor**
☐ **Other**_____

I authorize the release of all pertinent information, favorable or otherwise, to the Oregon Medical Board.

☞ **Signature of Applicant**_____

INSTRUCTIONS TO HOSPITAL/CLINIC/FACILITY: Please complete this form, sign and return it to the Board at the above address in an institution envelope. Please affix the seal of the hospital/institution. If the hospital/institution does not have a seal, so indicate. **All applicants for licensure have signed a general release, which relieves anyone of liability for information furnished in good faith.**

Type of Association: ☐ Employee ☐ Staff Member ☐ Locum Tenens ☐ Emergency Room ☐ Instructor
☐ Other_____

Dates of association: From (mo/day/yr) _____To (mo/day/yr)_____

Unusual Circumstances: The following apply to unusual circumstances that occurred during the applicant's association with your facility**. If you answer "yes" to questions 1-4 or "no" to question 5, please explain briefly on page 2 of this form, and attach copies of any documentation.**

1. Were any limitations imposed on the privileges approved for the applicant? ☐ YES ☐ NO
2. Was the applicant ever revoked, suspended, restricted, limited, reprimanded, placed on probation or otherwise disciplined? ☐ YES ☐ NO
3. Was the applicant requested to voluntarily resign? ☐ YES ☐ NO
4. Were there any concerns regarding the applicant's judgment, medical knowledge, performance or emotional stability? ☐ YES ☐ NO
5. If the applicant has/had **staff privileges** was the applicant in good standing? ☐ YES ☐ NO

Affix Institutional Seal Here If Available

Signature
Print Name Date Signed / /
Specialty Depart.
Name of Facility
Mailing Address
City State Zip
Phone Number ( )

Use this page to provide an explanation to a "yes" response to questions 1-4 or a "no" response to question 5 on page 1 of this Verification of Practice, Employment, Staff Membership form.

1. Were any limitations imposed on the privileges approved for the applicant?

2. Was the applicant ever revoked, suspended, restricted, limited, reprimanded, placed on probation or otherwise disciplined?

3. Was the applicant requested to voluntarily resign?

4. Were there any concerns regarding the applicant's judgment, medical knowledge, performance, or emotional stability?

5. If the applicant has/had staff privileges was the individual in good standing?

REACTIVATION OF LICENSE

OREGON MEDICAL BOARD
1500 S.W. 1st Avenue, #620, Portland, OR 97201-5847
(971) 673-2700 www.oregon.gov/omb

MD/DO/DPM LICENSURE - FAXED RESPONSES NOT ACCEPTED

VERIFICATION OF LICENSURE AND CERTIFICATION OF STATE BOARD WRITTEN EXAMINATION GRADES

INSTRUCTIONS: Applicant who has ever applied for UNLIMITED licensure in any state must complete this form and send it directly to the State Board to be completed and returned to the OREGON MEDICAL BOARD. **Contact each state Board to determine required fee needed to be submitted with your request.**

Last Name **First Name** **Middle Name**

Other names you have been known by

Street Address

City, State, Zip

Date of Birth **Social Security Number**

License Number **Date Issued**

This is your authorization to release any information in your files, favorable or otherwise, to the OREGON MEDICAL BOARD.

☞ _____

Signature of Applicant **Date signed**

STATE BOARD TO COMPLETE THIS SECTION AND RETURN TO THE OREGON MEDICAL BOARD

_____

License Number **Date issued**

Current Status Date Expired

MD/DO/DPM
- ☐ State Board Written Examination
- ☐ National Board Examination
- ☐ LMCC Examination
- ☐ USMLE Examination (Steps 1, 2 and 3)
- ☐ USMLE Examination (Combinations)
- ☐ Reciprocity with _____

OTHER ☐ Dentist ☐ Nurse ☐ Physician Assistant ☐ Acupuncturist ☐ Other _____

Is applicant currently the subject of a pending investigation by a licensing or disciplining authority in your state?
☐ Yes ☐ No (If yes, please attach details).

Has the applicant's license ever been denied, limited, surrendered, reprimanded, suspended or revoked?
☐ Yes ☐ No (if yes, please attach certified copy of legal documents)

I certify that to the best of my knowledge, the information above is true according to the records of the Board.

Name_____

Title_____

Name of Board _____

Signature_____**Date Signed**_____

REACTIVATION OF LICENSE

OREGON MEDICAL BOARD
1500 S.W. 1st Avenue, #620
Portland, Oregon 97201-5847
(971) 673-2700 www.oregon.gov/omb

MD/DO/DPM LICENSURE FAXED RESPONSES NOT ACCEPTED

REQUEST FOR DISCIPLINARY INQUIRES - FEDERATION

ALL applicants for licensure must complete this form OR the form on the appropriate FEDERATION website below and forward it directly to the FEDERATION at the address shown below.

MD/DO APPLICANTS SEND TO:	DPM APPLICANTS SEND TO:
DISCIPLINARY INQUIRIES Federation of State Medical Boards P.O. Box 619850 Dallas, TX 75261-9850 http://www.fsmb.org/fpdc_data_inquiry.html **NO FEE**	DISCIPLINARY INQUIRIES Federation of Podiatric Medical Boards 6551 Malta Drive Boynton Beach, FL 33437 https://www.fpmb.org/orderreports/index.asp **$50 fee (CHECKS TO FPMB)**

PLEASE PROVIDE A DISCIPLINARY SEARCH FOR:

Last Name First Name Middle Name

Other names you have been known by

Street Address

City, State, Zip

Date of Birth

Social Security Number (required for identification purposes)

Medical School of Graduation and Location Date of Graduation

FEDERATION: PLEASE MAIL COMPLETED RESPONSE TO THE OREGON BOARD

Instructions for Registration of Oregon License
REACTIVATION

Read Instructions **Before** Completing Reactivation Registration Form.

PLEASE NOTE: These instructions refer to the one-page reactivation registration form.

- Instructions are numbered to correspond to the numbers on the form.
- Business and addresses designated as mailing addresses are available to the public, under Oregon law (ORS192.420).
- For future addresses, please include **effective date.**
- Do not write in upper right hand box on application - for office use only.

APPLICATION FOR REGISTRATION

1. - 2. MAILING ADDRESS. Please write or type in the address that is the best address for our mail to reach you. This mailing address will be made available to the public. Check what type of mailing address it is (business, residence, or other). If you will be moving in the near future (next six months or so), please let us know the date when we should stop sending mail to this address. If you provide a PO Box, you must also provide the corresponding street or physical address, even if we will not be using it for mail delivery.
NOTE: A person's license to practice under this chapter automatically lapses if the licensee fails to notify the board of a change of location not later than the 30th day after such change. Refer to ORS 677.228 (1)(b).

3. NONREFUNDABLE FEES and STATUS.

- ✓ If you have been informed by Board staff (dee.hudnall@state.or.us) or (971) 673-2700, that you owe back registration renewal fees plus a late fee, write this amount next to the status you wish to have after you reactivate. These fees are nonrefundable and nontransferable; they cannot be credited or prorated. **NOTE**: You may not owe any registration fees if you have continued to pay the annual or biennial registration renewal fees.
- ✓ Oregon doctors pay registration fees on a biennial basis (once every two years). There are only two exceptions: Doctors in approved post-medical school training programs (residency) may pay their registration fees yearly. Doctors with Emeritus status must register yearly.
- ✓ Read status descriptions below to determine your status and check the appropriate choice on the **reactivation registration form**. There are five statuses described on this form: Active, Active-Military/Public Health, Inactive, Locum Tenens, and Emeritus. Read all descriptions (both sides of form) before marking your choice or calling us for assistance.
- ✓ Not all Oregon licensees are eligible for Active status under Oregon law (ORS 847-008-0015). Please contact our office if you have questions about your eligibility or need for a particular status. Email**:** omb.info@state.or.us or (971) 673-2700.

STATUS DEFINITIONS

- **ACTIVE**
  Reserved for doctors who are or will be actively practicing medicine in Oregon within the next three (3) months, as evidenced by a business address (OAR 847-008-0015).
  - ✓ Can be granted without a known business address for a period of three (3) months.
  - ✓ Can be granted for doctors who will be arriving in Oregon after three months from reactivation date, who have a definite business address, and will be arriving within six (6) months of reactivation. (1 additional form required.)
  - ✓ Can be granted to doctors living and/or practicing within certain bordering regions of California, Idaho, Nevada, or Washington. Call the Call Center for details.

- **ACTIVE - MILITARY/PUBLIC HEALTH**
  For doctors who are in the military or public health service only (OAR 847-008-0015). This allows military/public health doctors to remain Active to meet military/public health service requirements, regardless of where they may be stationed. These doctors may register as Active – Military/Public Health under these conditions:
  - ✓ Oregon must be the licensee's official state of residence. Please provide the official Oregon address.
  - ✓ The licensee **must request** Military/Public Health status in the **form of a letter** accompanying the registration form and include a copy of their military identification card and a copy of their Defense Finance & Accounting Service Military Leave & Earnings Statement.
  - ✓ The Active registration fee must be paid.
  - ✓ Military/Public Health status prohibits Oregon practice, unless as directed by the military or public health authorities.
  - ✓ Licensee must reactivate to unlimited Active status before beginning Oregon practice.
  - ✓ Contact the Call Center staff for details. Email**:** omb.info@state.or.us or (971) 673-2700.

- **INACTIVE**
  For doctors who are not living and practicing in Oregon, or for doctors living in Oregon, but not practicing medicine (OAR 847-008-0025).

- **LOCUM TENENS**
  For doctors who do not live in Oregon or in bordering regions, but who plan on practicing intermittently within Oregon (OAR 847-008-0020). Locum Tenens doctors must notify the Board in advance and in writing of the dates, places, and telephone numbers of each Locum Tenens practice. A form for this purpose will be sent with the certificate of registration. It may be duplicated for your use. We accept notification by fax and by standard mail.

- **EMERITUS**
  For doctors who do not practice medicine for pay or any other type of remuneration; these doctors volunteer their medical skills only (OAR 847-008-0030). These doctors must register annually.

NOTE: Physicians with Active-Military/Public Health service, Active-Teleradiology, Active-Telemonitoring, Inactive, or Locum Tenens status who move or return to Oregon to practice must complete an Affidavit of Reactivation and be granted Active status prior to beginning practice in Oregon.

4. **Enter your current business STREET address** or "as above" if it is the mailing address. **Enter your current business phone number.** If no business address, enter an appropriate remark, e.g., "pending," "retired," "none," etc. **DO NOT LEAVE BLANK**. Enter FUTURE OREGON BUSINESS address and phone number if applicable. Enter date future business address is effective. Check **YES** or **NO** regarding your preferred mailing address at your future business address.

5. **Enter your current residence STREET address and phone number**. If mail cannot be delivered to this address, make notation in margin. **DO NOT LEAVE BLANK**. Enter FUTURE OREGON RESIDENCE street address and phone number if applicable. Enter date future residence address is effective. Check **YES** or **NO** regarding your preferred mailing address.

6. - 8. Enter the required information for these sections. A specialty list follows these instructions. **CHOOSE ONLY ONE SPECIALTY** from the list below. Since only one specialty can be listed, choose the specialty that best describes your primary practice. Check **YES** or **NO** regarding Board Certification for **THIS** specialty.

9. **DISPENSING DRUGS**. Definition: A "dispensing physician" is one who purchases prescription drugs for the purpose of dispensing them to patients or other individuals entitled to receive the prescription drug and who dispenses them accordingly.

   Dispensing does **not** include distribution of free samples; drugs, vaccines, or other parenterals administered in the office; or writing prescriptions that will be filled at a pharmacy. Physicians or podiatric physicians who dispense drugs in Oregon without first registering with the Board may be fined $100, and may be subject to further disciplinary action by the Board.

10. **OREGON STAFF PRIVILEGES**. Only active or locum tenens physicians complete item #10.

11. **LOCUM TENENS**. Complete if applicable. We will send you a form after your license is reactivated. Use this form to provide the Board with details of your upcoming Oregon practice (dates, phone numbers, and locations). You may make copies of the form as needed. Return the completed form to the Board **before each Locum Tenens position in Oregon**. You may mail or fax it to us.

12. **MD/DO/DPM SIGNATURE. You must sign and date this form**. Photocopies, stamps, or proxies are not acceptable.

SPECIALTY LIST.

Choose the one specialty that most closely describes your area of practice. **(see Registration #7)**

Acupuncturist..... ACUP	Dermatology..... D	Industrial Med..... IND	Oral Surgery..... OS	Preventative Med..... PM
Addiction Medicine... ADM	Diabetes..... DIA	Infectious Diseases.... ID	Orthopedic Surgery.... ORS	Proctology..... PR
Adolescent Med..... ADL	Diagnostic Radiol..... DR	Internal Med..... I	Otology..... OT	Psychiatry ..... P
Allergy..... ..... A	Emergency Med..... EM	Legal Med ..... LM	Oto/Laryn/Rhin..... OTO	Psychiatry Neurol..... PN
Allergy/Immunol..... AI	Endocrinolgy..... END	Max/facial Surgery.... MFS	Pathology..... PATH	Psychoanalysis..... PYA
Anesthesiology..... AN	Family Medicine..... FM	Med Genetics..... GEN	Pedatrics..... PD	Psychoso Med..... PYM
Aviation Med..... AM	Forensic Pathology.... FOP	Neo/Perinatal Med.... NPM	Pediatric Allergy..... PDA	Public Health..... PH
Cardiology..... C	Gastroenterology..... GE	Nephrology..... NEP	Pediatric Cardiol..... PDC	Pulmonary Diseases... PUD
Cardiothoracic Surg... CDS	General Practice..... GP	Neurological Surg..... NS	Pediatric Endocrin..... PDE	Radiation Oncol..... TR
Cardiovascular Dis.... CD	General Surgery..... GS	Neurology ..... N	Pediatric Hem/Onc.... PHO	Radiology..... R
Cardiovascular Surg...CDS	Geriatrics..... GER	Nuclear Med..... NM	Pediatric Nephrol..... PNP	Rheumatolgy..... RHU
Child Neurology..... CHN	Gynecology..... GYN	Nutrition.....NTR	Pediatric Radiology... PDR	Sports Med..... SM
Child Psychiatry..... CHP	Hand Surgery..... HS	Obstetrics..... OBS	Pediatric Surgery..... PDS	Therapeutic Radiol.... TR
Claims Adjudicator.... CL ADJ	Head/Neck Surgery.... HNS	Obstetrics/Gyn..... OBG	Pharmacology..... PHARM	Thoracic Surgery..... TS
Clinical Pathology..... CLP	Hematology..... HEM	Occupational Med.....OM	Phys Med & Rehab.... PMR	Traumatic Surgery..... TRS
Colon/Rectal Surg..... CRS	Hospital Admin..... HAD	Oncology..... ONC	Plastic Surgery..... PL	Urology..... U
Critical Care Med..... CCM	Immunology..... IG	Ophthalmology..... OPH	Podiatrist..... DPM	Vascular Surgery..... VS

Oregon Medical Board
1500 SW 1st Ave., Ste 620
Portland, Oregon 97201-5847
(971) 673-2700 www.oregon.gov/omb

Above Space for Official Use Only

Application for Registration: Reactivating MD/DO/DPM

LICENSE #: _____ DATE LICENSED: _____ CURRENT STATUS: _____

REINSTATEMENT APPROVED FOR: ☐ **Inactive** PER: _____ EFFECTIVE: _____

REACTIVATION APPROVED FOR: ☐ **Active** ☐ **Locum Tenens** ☐ **Emeritus** PER: _____ EFFECTIVE: _____

Important: ***Please read instructions before completing application.*** All numbered items must be completed and form signed**.**

(1) **CURRENT MAILING ADDRESS** (Mailing address is available to the public):

_____
(Last name) (MD/DO) *(First)* *(Middle)*

_____
(Street address, PO box number, etc.)

_____
(City) *(State)* *(Zip)*

(2) This mailing address is effective until: _____
( ) Practice
( ) Residence
( ) Other _____
(*Billing, PO box number, etc.*)

(3) **NONREFUNDABLE FEES**: Make check payable to "Oregon Medical Board" or complete credit card payment information on reverse side.

_____ ☐ **ACTIVE** (Practice in Oregon or in Military/Public Health & Oregon is your official address, or practice from out-of-state via Teleradiology or Telemonitoring – Requires agency letter of verification)
_____ ☐ **INACTIVE** (Not practicing in Oregon.)
_____ ☐ **LOCUM TENENS** (See instructions and **complete item #11 below**.)
_____ ☐ **EMERITUS** (Retired, volunteer nonremunerative practice.)

(4) **CURRENT PRACTICE STREET ADDRESS**:

_____

_____

Current Practice Telephone #: _____
Will above address change in the near future? ☐ **YES** ☐ **NO**

(5) **CURRENT RESIDENCE STREET ADDRESS**:

_____

_____

Current Residence Telephone #: _____
Will above address change in the near future? ☐ **YES** ☐ **NO**

FUTURE PRACTICE STREET ADDRESS: Effective _____

_____

_____

Future Practice Telephone #: _____
Will above address be your **MAILING** address? ☐ **YES** ☐ **NO**

FUTURE RESIDENCE STREET ADDRESS: Effective _____

_____

_____

Future Residence Telephone #: _____
Will above address be your **MAILING** address? ☐ **YES** ☐ **NO**

(6) Oregon Practice County:_____

(7) Specialty: _____

(8) Board Certified by the ABMS (MD/DO), AOA (DO), or the ABPOPM or ABPS (DPM) in this specialty? ☐ **YES** ☐ **NO**
(Requires documentation in license file.)

(9) Will you purchase drugs to give or sell to your **Oregon** patients during the current registration period? ☐ **YES** ☐ **NO**
(***IMPORTANT*** *- see instructions for definition of dispensing physician*)

(10) List all Oregon Staff privileges, permanent or pending, (hospital name and location) - Active or Locum Tenens physicians only:

_____

(11) Licensees who wish Locum Tenens status - list conditions, dates, place and contact name of proposed Oregon practice **OR** list name, address and telephone number of Locum Tenens agency.

_____

(12) **I certify that the information submitted by me is true, accurate and complete to the best of my knowledge.**

→ MD/DO/DPM Signature: _____ Date: _____

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

Credit Card Payment

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

$ _____
Amount

_____
Company Name

_____
Printed Name as it Appears on Card

_____
Signature

_____
Phone Number with Area Code

_____
Cardholder's Mailing Address

_____

				–				–				–						-					

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