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

Above Space for Official Use Only

Key Code	1101 (MD)	1102 (DO)	1230 (DPM)
	$375	$375	$340

Applicant #	License #	Date License Issued:
SPACE ABOVE THIS LINE FOR BOARD USE ONLY		

APPLICATION FOR LICENSURE

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

Please see the terms and conditions of use for the Online Status Report in the Agreement at www.oregon.gov/BME/agreement.pdf.

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

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

➔ Please indicate your mailing address: ☐ **Practice/Training** ☐ **Residence** ☐ **Other**

11. **PREMEDICAL EDUCATION** Name and location of college/university			
BEGINNING DATE	ENDING DATE (Mo., Yr.)	DEGREE	DATE OF DEGREE
12. **ADDITIONAL PREMEDICAL EDUCATION** Name and location of college/university			
BEGINNING DATE	ENDING DATE (Mo., Yr.)	DEGREE	DATE OF DEGREE

13. **MEDICAL EDUCATION** Name, location of Medical/Osteopathic/Podiatric School	DATES OF ATTENDANCE	BEGINNING DATE Mo. Day Yr.	ENDING DATE Mo. Day Yr.
	1st Year		
	2nd Year		
	3rd Year		
	4th Year		
	5th Year		
	6th Year		

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

15. **EXAMINATION.** Indicate the examination(s) you have taken.

☐ USMLE ☐ Step 1 **Date** Passed _____ ☐ Step 2 **Date** Passed _____ ☐ Step 3 **Date** Passed _____

☐ NBME (MD)
☐ NBOME (DO) ☐ Part I Date Passed _____ ☐ Part 2 Date Passed _____ ☐ Part 3 Date Passed _____
☐ NBPME (DPM)

☐ FLEX ☐ Day 1 Date Passed _____ ☐ Day 2 Date Passed _____ ☐ Day 3 Date Passed _____
State where taken _____ State where taken _____ State where taken _____

☐ FLEX ☐ Comp 1 Date Passed _____ ☐ Comp 2 Date Passed _____

☐ LMCC Date passed _____

	State where taken	Date passed
☐ SPEX ☐ COMVEX	_____	_____

☐ ECFMG Date Passed _____ Date certificate issued _____

16. **ALL LICENSES APPLIED FOR**: (even if not current) State/province/country	TYPE (MD/DO/ DPM, RN, EMT, PA,)	LICENSE/CERTIFICATE Issued Mo Yr Number	GRANTED	EXPLAIN Denied (explain)	Pending	PERM or TEMP	CURRENT Yes	No

17. Have you ever applied for or obtained an unlimited or limited license in the State of Oregon?

☐ NO ☐ YES If Yes, Show License #: _____ Date Issued: _____

18. STAFF PRIVILEGES. List ALL hospitals in which you have ever applied for staff privileges for practice or military service. Do NOT include hospital training programs. (Use only standard abbreviations). A curriculum vitae is NOT acceptable.

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.

19. **CHRONOLOGY OF ACTIVITIES.** List **ALL** activities including training, employment, locum tenens, vacations in date order after medical/ osteopathic/podiatric school up to and including the present date. Account for all periods of time and indicate specialty field for all training programs. Use standard abbreviations. Only list vacations of one month or longer between each activity. **(A curriculum vitae is NOT acceptable)**

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		7 00	11 06

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

20. **PERSONAL HISTORY QUESTIONS**. 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 attach a complete written explanation of the event(s) or condition(s), including dates, names, addresses, circumstances, and results along with your returned application. Use the form at http://egov.oregon.gov/BME/MD-DO_Application/Personal_History_Explan_Form.pdf.

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?

21. **DATE OF BIRTH** (Mo. Day Yr.)

22. **PLACE OF BIRTH** City, State, or country

23. **PHYSICAL DESCRIPTION**

HEIGHT WEIGHT	EYES	HAIR

24. GENDER

☐ MALE ☐ FEMALE

25. **MILITARY SERVICE** (Branch) FROM (Mo. Day Yr.) _____

Active Duty Only _____ TO (Mo. Day Yr.) _____

(Branch) FROM (Mo. Day Yr.) _____

_____ TO (Mo. Day Yr.) _____

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

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

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.

27. **OREGON PRACTICE INFORMATION** **If you will begin training in Oregon, show N/A. See 28 below.**

Hospital/Clinic. Medical group

Street address

City, state, zip

Proposed Beginning Date of Practice: _____

28. **DATES OF OREGON TRAINING** (CURRENT OR FUTURE ONLY)

From: To:

☐ Residency (list hosptial) _____

☐ Residency Specialty _____

☐ Fellowship (list hospital) _____

☐ Fellowship Specialty _____

29. **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

I, _____, being first duly sworn, depose and say that I am the
(Applicant, TYPE or PRINT full legal name)
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/podiatry during the processing of this application and the time that I am a licensee of this board. I have read and understand the terms and conditions of use for the Online Status Report in the Agreement at www.oregon.gov/BME/agreement.pdf.

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)

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

Notary signature ☛ _____

Notary Public for _____

My commission expires _____

Affix a Legible Seal in This Space

NOTARIZE ON THIS FORM ONLY

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