OREGON BOARD OF MEDICAL EXAMINERS
1500 S.W. 1st Avenue, #620, Portland, OR 97201-5847
(971) 673-2700 (8:00 AM - 5:00 PM)

DPM LICENSURE - FAXED RESPONSES NOT ACCEPTED

VERIFICATION OF PODIATRIC HOSPITAL PRIVILEGES TO PERFORM ANKLE SURGERY

INSTRUCTIONS TO APPLICANT: Complete UPPER portion of form and forward to any hospital where employed or where hospital staff membership has been requested and where ankle surgeries have been performed. Hospital is to complete LOWER portion of form and affix the seal of the hospital. If hospital does not have a seal, please so indicate. Return form **DIRECTLY** to the OREGON BOARD OF MEDICAL EXAMINERS.

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

Other names you have been known by

Street Address

City, State, Zip

Date of Birth **Social Security Number**

Name of Hospital at the time of association **From (mo/day/yr)** **To (mo/day/yr)**

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

This is your authorization to release all pertinent information to the Oregon Board of Medical Examiners.

☞ **Signature of Applicant**_____

PLEASE VERIFY ANKLE SURGERY PRIVILEGES AT YOUR HOSPITAL FOR THE ABOVE APPLICANT.
You may attach a copy of the list of privileges your hospital granted this podiatrist.

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

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

Please indicate the age group of the patients for each type of ankle surgery privileges approved by the hospital: "N" = Neonates (1 to 30 days), "I" = Infants (30 days to 1 year), "C" = Children (1 year to 15 years), and "A" = Adult (15 years and older).

Privilege Granted for N, I, C, A	No. Times Performed in past 3 Years	ANKLE SURGERY PROCEDURES
		1. Closed Reduction of fracture
		2. Open reduction of fracture
		3. Arthroscopy
		4. Arthrotomy
		5. Excise benign/malignant lesions – soft tissue/ osseous
		6. Arthrodesis
		7. Other:

Program Director's Signature **Affix Institutional Seal Here**

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