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

APPLICATION FOR A LIMITED LICENSE (MD/DO/DPM)

APPLICATION INSTRUCTIONS AND INFORMATION

A Limited License, Postgraduate, Fellow, Medical Faculty, or Visiting Professor may be granted to you once you have completed the limited license form, submitted it to the Board with the limited license fee, the Board has received the required documentation as listed below and has satisfactorily processed the application. Submit your application and supporting documentation ***at least one month prior to the date you intend to begin practice***. You should plan on allowing even more processing time during the spring and summer months as this is the busiest time of the year.

FEE

The fee for the limited license is **$185.00.** Make your check payable to "Oregon Medical Board," or pay by credit card by completing the credit card form on Page 6 of the limited license application. **The limited license fee cannot be refunded, credited, transferred or prorated.**

DESCRIPTION OF THE LIMITED LICENSES

Please check (✓) the limited license for which you are applying. Review the following information concerning the limitations of the various types of limited licenses issued by the Board.

Following the title of each limited license is a reference to the administrative rule where this limited license can be found. All the Board's administrative rules can be found on the Board's web site at www.oregon.gov/OMB. Find Rules and Statutes on the left side of the opening Board web page, and then click on The Oregon Administrative Rules. The Board's administrative rules are OAR 847, and within OAR 847, Division 010 contains descriptions of the limited licenses. Division 020 also contains descriptions of the Limited License, Visiting Professor and Limited License, Medical Faculty.

Limited License, Postgraduate (LLPG) (OAR 847-010-0051)

The LLPG limits the physician's practice to an accredited training program. The physician may NOT work outside the accredited training program. Moonlighting is NOT allowed under this limited license. This license is granted for one year and can be renewed for all subsequent years of an accredited training program.

Limited License, Fellow (LLF) (OAR 847-010-0056)

The LLF limits the physician's practice to a supervised fellowship program of an approved school of medicine or affiliated teaching institution. The physician may NOT work outside a training program. Moonlighting is NOT allowed under this limited license. This limited license can be issued annually for a total of two years only.

Limited License, Medical Faculty (LLMF) (OAR 847-010-0063, OAR 847-020-0140)

The LLMF is issued to a physician who receives a full time faculty position in an accredited medical school in the state. The limited license allows practice only as a necessary part of the duties of the faculty position as approved by the Board. Moonlighting is NOT allowed under this limited license. The LLMF can be issued annually for a total of four years only.

Limited License, Visiting Professor (LLVP) (OAR 847-010-0052, OAR 847-020-0140)

The LLVP is issued for a physician who has received a teaching position in an approved medical school or affiliated teaching institution in the state. The limited license allows practice only as a necessary part of the duties of the teaching position as approved by the Board. Moonlighting is NOT allowed under this limited license. The LLVP can be issued annually for a total of two years only.

DOCUMENTATION REQUIRED TO PROCESS THE LIMITED LICENSE APPLICATION

Limited License, Postgraduate: Request a letter from the Oregon medical school (OHSU) or teaching hospital providing dates of training if during the year, or your name is on the list from OHSU or teaching hospital if you are appointed at summer start time.

Limited License, Postgraduate <u>for an out-of-state resident doing an elective rotation in Oregon</u>: Request a letter from the Oregon location and a letter from the current out-of-state postgraduate program providing dates of training and confirming that the training in Oregon is part of the current training program.

Limited License, Fellow: Request an appointment letter from the Oregon Health and Science University (OHSU) or one of the affiliated teaching hospitals if you are appointed during the year, or your name is on the list from OHSU or teaching hospital if you are appointed at summer start time.

Limited License, Medical Faculty:

- Provide documentation that you are a United States citizen or are legally admitted to the United States.
- Request the Dean of the medical school (OHSU) to certify to the Board that you have been appointed to a full-time faculty position, that a position is available, and that because you have unique expertise in a specific field of medicine the medical school considers you to be a valuable member of the faculty.
- Document that
  - You have been licensed to practice and have practiced medicine and surgery for not less than four years in another state or country whose requirements are satisfactory to the Board; **or**
  - You have engaged in the practice of medicine in the United States for at least four years in approved hospitals; **or**
  - You have completed a combination of such licensed practice and training.
- You may be required to take and pass an examination by the Board.

You will be under the direction of the head of the department and may practice medicine only as a necessary part of the duties as approved by the Board.

Limited License Visiting Professor:

- Provide documentation of graduation from a school of medicine.
- Provide curriculum vitae.
- Request the head of the Oregon medical school or teaching institution's department in which you are to be appointed to certify in writing to the Board that you have been offered a teaching position under the direction of the department.

You will be under the direction of the head of the department and may practice medicine only as a necessary part of the duties as approved by the Board.

<u>RENEWAL OF YOUR LIMITED LICENSE</u>

- All limited licenses must be renewed annually. A new application form must be completed and a fee must be paid each time the limited license is renewed.
- A Limited License, Postgraduate may be renewed for all years of training.
- A Limited License, Fellow may be renewed for one additional year only (2 years total).
- A Limited License, Visiting Professor may be renewed for one additional year only (2 years total).
- A Limited License, Medical Faculty may be renewed for three additional years only (4 years total).

<u>PLEASE NOTE</u>

- Your LIMITED license number does not become your permanent license number when you are granted an UNLIMITED license to practice in Oregon.
- It is the responsibility of the licensee to renew the limited license, if needed, before the date of expiration printed on the Certification of Registration.

<u>COMPLETING THE FORM</u>

Please complete ALL sections of the limited license application form. Incomplete or incorrectly completed forms will be returned, which will delay consideration of your limited license.

PAGE 1

Please provide all data/information requested on Page 1. As part of your application for license or renewal of your license you are required to provide your Social Security Number to the Oregon Medical Board. This is mandatory. The authority for this requirement is Oregon Laws 1997, chapter 746, section 117 (ORS 25.785), ORS 305.385, and 42 USC § 66 (a)(13). 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 enforcement by the Department of Revenue, by the Board for identification and investigative purposes only, and provided to entities for the collection of delinquent fines assessed by the Board, unless you authorize other uses of the number.

Do you want your practice address posted on the Board's Web site? For future planning, the Board is asking whether you would allow the Board to post your practice address on the OMB web site.

PAGE 2 CHRONOLOGY OF ACTIVITIES

List all activities from date of graduation from medical/osteopathic/podiatric school up to the present date. Include all training, practice, non-medical activities as well as any vacations of one month or longer between activities**. DO NOT SUBMIT A CURRICULUM VITA IN LIEU OF COMPLETING THIS PAGE.**

PAGES 3-4 PERSONAL HISTORY QUESTIONS

A "yes" response to a personal history question will require a review of your application. For this reason the application and fee should be submitted as soon as possible. Specific information is needed, both from you and the source, if any of the personal history questions are answered in the affirmative. Review the questions and your responses carefully. Incomplete information will delay the processing of your application.

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.
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

Questions 1 and 2

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 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 Individual Assessment and Evaluation; Discharge Summary and Discharge Plan for Continued Care or the equivalent. Letters/reports need to be sent directly to this Board.

Questions 3, 4 and 5

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 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 Individual Assessment and Evaluation; Discharge Summary and Discharge Plan for Continued Care or the Equivalent. Letters/reports to be sent 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 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.

PAGE 5 PERSONAL IDENTIFICATION

- Attach close-up passport quality photograph, taken within the past 90 days, signed in ink on the front, showing date taken.
- Enter your description showing gender, height, weight, hair color, eye color and date and place of birth.
- Sign the application in the presence of a Notary Public.

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Above Space for Official Use Only

Key Code	1041	1042	1043	1045
	$185	**$185**	**$185**	**$185**

Issue LL _____ PER _____ FROM _____ TO _____ LICENSE # LL_____
Type Staff Initials MM/DD/YYYY MM/DD/YYYY

SPACE ABOVE FOR USE OF OREGON MEDICAL BOARD ONLY

APPLICATION FOR A LIMITED LICENSE (MD/DO/DPM)

ALL LIMITED LICENSES ARE SUBJECT TO BOARD APPROVAL, ARE SUBJECT TO SPECIFIC REQUIREMENTS AND MAY BECOME IMMEDIATELY INVALID UNDER CERTAIN CONDITIONS, SUCH AS UNSATISFACTORY PERFORMANCE. NOTE: NO REFUND, CREDIT, TRANSFER OR PRORATING OF FEES ONCE SUBMITTED.

ENCLOSE PAYMENT IN THE AMOUNT OF **$185.00.**

Select the Limited License for which you are applying:

KEY		KEY	
1043	☐ **POSTGRADUATE**	1045	☐ **MEDICAL FACULTY**
1041	☐ **FELLOW**	1042	☐ **VISITING PROFESSOR**

I HEREBY APPLY FOR THE ABOVE LIMITED LICENSE FOR THE PERIOD FROM _____ TO _____
MM/DD/YYYY MM/DD/YY

IF YOU HAVE PREVIOUSLY HELD OREGON LICENSE, SHOW:
☐ **LIMITED LICENSE #** ☐ **UNLIMITED LICENSE #**

FULL LEGAL NAME Last Name First Name Middle Name ☐ MD ☐ DO ☐ DPM

OTHER NAMES USED Last Name First Name Middle Name ☐ MD ☐ DO ☐ DPM

CURRENT MAILING ADDRESS (IF APPLICABLE) Street City State Zip | Area code Phone no.

OREGON PRACTICE/TRAINING ADDRESS Street City State Zip | Area code Phone no.

Do you want your practice address posted on the Oregon Medical Board website? ☐ **YES** ☐ **NO**

OREGON RESIDENCE ADDRESS Street City State Zip | Area code Phone no.

E-MAIL ADDRESS | **SOCIAL SECURITY NUMBER**

SPECIALTY FOR TRAINING/PRACTICE IN OREGON | **ECFMG NUMBER** | **DATE ISSUED**

NAME & LOCATION OF MEDICAL/OSTEOPATHIC/PODIATRIC SCHOOL City, State/Country | **DEGREE (MM/DD/YYYY)**

I HAVE COMPLETED (OR SOON WILL) THE FOLLOWING EXAMINATIONS:

☐	**USMLE**	☐ **Step 1**	☐ **Step 2**	☐ **Step 3**		
☐	**National Board of Medical Examiners (MD)**	☐ **Part I**	☐ **Part II**	☐ **Part III**		
☐	**FLEX Examination**	☐ **Day I**	☐ **Day 2**	☐ **Day 3**	**-OR-**	☐ **Component 1** ☐ **Component 2**
☐	**National Board of Osteopathic Examiners (DO)**					
☐	**National Board of Podiatric Examiners (DPM)**					
☐	**Medical Council of Canada (LMCC)**					

ALL LICENSES APPLIED FOR: (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	NB	CURRENT YES	NO

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 activities. **(A curriculum vitae is NOT acceptable.)**

TYPE OF ACTIVITY (training, practice, vacation) **EXAMPLE**	**TRAINING LEVELS**	**SPECIALTY**	**NAME OF INSTITUTION OR PLACE OF PRACTICE AND MAILING ADDRESS**	**BEGINNING DATE** Mo Yr	**ENDING DATE** Mo Yr
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

PERSONAL HISTORY APPLICATION QUESTIONS

Limited License (MD/DO/DPM)

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 written explanation of the event(s) or condition(s), including dates, names, addresses, circumstances, and results along with your returned application. Use the space on page 4 of this form, or if you need more space, please use the form at: http://egov.oregon.gov/OMB/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? *(If you answer "Yes" to this question, please complete the Medical Professional Claims Information form at http://egov.oregon.gov/OMB/MD-DO_Application/Malpractice_Medical_Claims.pdf.)*
☐	☐	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.

Category _____ Question # _____
Category _____ Question # _____

PERSONAL IDENTIFICATION

Gender: _____

Height: (ft. & in.) _____

Weight: (lbs.) _____

Hair Color: _____

Eye Color: _____

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

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

ATTACH PHOTOGRAPH HERE

SIGN AND DATE FRONT

Photograph must be:
- 2" x 2" original passport quality photo
- taken within 90 days of application
- signed in ink
- show date taken on front side

Instant Polaroid snapshots with thick backing and computer scanned photos are **NOT** acceptable.

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 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 SEAL HERE	**Subscribed and sworn to before me this _____ day of _____20___** **Notary Signature☛** _____ **Notary Public for**_____ **My commission expires**_____

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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