OREGON MEDICAL BOARD
1500 SW 1st Ave, Suite 620 • Portland, OR 97201-5847
(971) 673-2700 or (503) 877-6263 *(toll free in Oregon)*
Web site: www.oregon.gov/omb

ACUPUNCTURE LIMITED LICENSE VISITING PROFESSOR APPLICATION INSTRUCTIONS

Applications are valid for one year from the date filed. Submit the fee with the application form. The Board must receive all required current documentation in order to be considered for licensure. Documentation required from other sources may arrive before the application form and filing fee. **Please be sure to notify the Board of any change in your address or phone number as soon as possible.**

COMPLETING THE APPLICATION FORM:

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

PAGE 1

Indicate the **dates** you are requesting for the limited license. The Limited License Visiting Professor can be granted for one year and may be renewed for two one-year periods, for a total of three years.

Show any **previous license(s)** issued by the Oregon Medical Board that you have held.

Name: Show your full, ***legal*** name. If your name includes Jr., II, III, initial only, or no middle name, please indicate this on the application. Your complete legal name must be shown on your certificate of registration and all licensees must practice their profession under the name that appears on their license. You must be licensed only under a legally documented name.

Other Names: List all other names (first, middle, and last) that you have used since birth.

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.

Addresses and Phone Numbers: Provide your COMPLETE current mailing, Oregon business, and Oregon residence addresses. Also, include all telephone numbers so that Board staff can call you if necessary.

Indicate your **Oregon teaching institution:** the Oregon College of Oriental Medicine (OCOM) or the National College of Natural Medicine (NCNM).

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

Acupuncture Training Program/Diploma Date: Provide the name and location of the Acupuncture program from which you graduated. Also, provide the graduation date as shown on your diploma.

NCCAOM Certification Date/Number: Check the YES or NO box to indicate whether you are certified by the NCCAOM. If you are certified, provide your certification date and certificate number.

Acupuncture Licenses: List all acupuncture licenses and/or certificates that you have held.

PAGE 2

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

PAGE 3 & 4

PERSONAL HISTORY QUESTIONS: If you answer any of the questions "yes," furnish ***thorough*** *(who, what, when, where, why, and how)* details on page 4. Attach an addendum if necessary, signed and dated. Failure to provide ***all*** details will delay the processing of your file.

CATEGORY I

Question 1
Applicant to provide full details to include state/province, reasons/circumstances, and possible disciplinary action.
Licensing Board to provide full details, and include copies of any legal documents.

Question 2
Applicant to provide full details to include state/province, type of examination failed, and dates and grades (if known) for each failure.

Question 3, 4, and 5
Applicant to provide states, dates, and reasons/circumstances.
Licensing Board to provide full details including reasons and include copies of any legal documents.

Question 6
Applicant to provide full details including dates and reasons.
State Narcotic Office/Drug Enforcement Administration (DEA) to provide full details and include copies of any legal documents.

Question 7
Applicant to provide full details of the arrest, the dates, places, and disposition of the case.
Police Department/Court to provide a Certified Copy (with court seal affixed) of the original charge, the judgment, the sentence and/or the dismissal order or other such documents which reflect the disposition of the matter.

Question 8
Applicant to provide full details to include the agency conducting the investigation as well as the reasons for the criminal or civil investigation. Provide a copy of documents, reports and correspondence.
Investigating Agency to provide full details concerning to reasons for the investigation.

Question 9
Applicant to provide full details to include details of the case, where/when incident occurred, disposition of the case, judgment, etc. Please indicate if the case is still pending. Provide a copy of the documents, reports and correspondence.
Court to provide full details concerning reasons for the investigation.

Question 10
Applicant to provide full details to include the agency/party with which the settlement was entered as well as the reasons for and conditions of the settlement. Provide a copy of the documents, reports and correspondence.
Agency/Party to provide full details concerning the circumstances, results, and copies of any legal documents.

Question 11

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

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

Question 12

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

Question 13

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

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

Question 14

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

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

CATEGORY II

Question 1

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

Treatment Provider to provide a full report to include Family History/Physical; Individual Assessment and Evaluation; Psychiatric Evaluation; Psychosocial Assessment; Discharge Summary and Discharge Plan for Continued Care or the equivalent, and send letters and/or reports directly to this Board.

Question 2

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

Treatment Provider to provide complete details of treatment or counseling, including dates, diagnosis, treatment and prognosis. Request the appropriate official at the hospital to provide a full report to include Family History/Physical; Individual Assessment and Evaluation; Psychiatric Evaluation; Psychosocial Assessment; Discharge Summary and Discharge Plan for Continued Care or the equivalent, and send all letters and/or reports directly to this Board.

Question 3

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

Treatment Provider to provide complete details of treatment or counseling, including dates diagnosis, treatment, and prognosis. Request the appropriate official at the hospital to provide a full report to include Family History/Physical; Individual Assessment and Evaluation; Psychiatric Evaluation; Psychosocial Assessment; Discharge Summary and Discharge Plan for Continued Care or the equivalent, and send all letters and/or reports directly to this Board.

Question 4

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

Treatment Provider to provide a full report to include Family History/Physical; Individual Assessment and Evaluation; Psychiatric Evaluation; Psychosocial Assessment; Discharge Summary and Discharge Plan for Continued Care or the equivalent, and send all letters and/or reports directly to this Board.

Police Department/Court to provide a Certified Copy (with court seal affixed) of the original charge, the judgment, the sentence and/or the dismissal order or other such documents which reflect the disposition of the matter. Letters/reports to be sent directly to this Board.

Question 5

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

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

Question 6

Applicant to provide full details and dates to include the name and location of the diversion program, regulatory board, healthcare program or facility, and/or court, and reasons for and results of entering the program.

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

PAGE 5

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

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

DOCUMENTS THE APPLICANT IS REQUIRED TO SUBMIT
(Only required for initial application; not required for renewal/extension requests.)

DO NOT send original documents - photocopies are acceptable unless otherwise stated. Copies must be legible. All documents must be no larger than 8 ½ x 11 inches.

- **Acupuncture Diploma:** Submit a copy of your acupuncture diploma. If in a language other than English, the Board requires an OFFICIAL, WORD-FOR-WORD ENGLISH TRANSLATION in addition to the copy of the original diploma. See below for acceptable translators.

- **Acupuncture License:** Submit a copy of your current acupuncture license. If in a language other than English, the Board requires an OFFICIAL, WORD-FOR-WORD ENGLISH TRANSLATION in addition to the copy of the original license.

  The following are acceptable translators:
  - An employee of a professional translating company
  - A member of the American Translators Association
  - A faculty member of the modern languages or linguistic department of a United States college or university

  The translations must be on official letterhead and bear the translator's certification seal. All information appearing on the document must also appear on the translation each time it appears on the original document. This includes pre-printed information, such as the letterhead of a university, titles, etc.

MAILED DIRECTLY TO THE BOARD

Initial Application: The Oregon school of acupuncture (OCOM or NCNM) must certify in writing to the Board that the school has offered the applicant a teaching position, which will be under the direction of the head of the department, and that the applicant will not be permitted to practice acupuncture unless as a necessary part of the applicant's teaching position.

Renewal/Extension requests: The Limited License Visiting Professor can be granted for one year and may be renewed for two one-year periods, for a total of three years. The Oregon school of acupuncture (OCOM or NCNM) must request in writing that the license be extended for an additional year based upon academic necessity. The school must again certify that the school has offered the applicant an extension of the teaching position, which will be under the direction of the head of the department, and that the applicant will not be permitted to practice acupuncture unless as a necessary part of the applicant's teaching position. **Request is due 30 days prior to beginning date of renewal**.

APPLICATION COMPLETION CHECKLIST
ACUPUNCTURE LIMITED LICENSE VISITING PROFESSOR

Please use this sheet to help you keep track of what you need to do to complete your file. Most often, delays are due to incomplete or inaccurate information. You will receive status letters when the Board receives documentation regarding your application. Please contact the Licensing Call Center at 971-673-2700 if you have any questions.

DOCUMENTS REQUIRED FROM THE APPLICANT (initial application and renewals):

- ❑ Completed notarized application form, including passport photograph
- ❑ Application fee of $75.00

DOCUMENTS REQUIRED FROM THE APPLICANT (initial application only):

- ❑ A photocopy of your Acupuncture school diploma and copy of official translation if applicable
- ❑ A photocopy of your current Acupuncture license and copy of official translation if applicable

REQUIRED FROM THE OREGON ACUPUNCTURE SCHOOL SENT DIRECTLY TO THE BOARD:

- ❑ Verification of teaching position from the Oregon acupuncture school (OCOM or NCNM)

RETAIN A COPY OF YOUR COMPLETED APPLICATION FOR YOUR FILES.

While an applicant, please use the form at the following link to submit any address change(s) to the Board: http://egov.oregon.gov/OMB/MD-DO_Application/Applicant_Address_Change.pdf.

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Web site: www.oregon.gov/omb

Above Space for Official Use Only
Key Code 1382
$75

Issue LLVP PER _____ VALID From _____ To _____ License # LL_____

SPACE ABOVE FOR USE OF OREGON MEDICAL BOARD ONLY

APPLICATION FOR ACUPUNCTURE
LIMITED LICENSE VISITING PROFESSOR

1) Applications are valid for one year from the date filed. Submit this application with the $75.00 fee. **FEES ARE NON-REFUNDABLE.** Make check payable to the "Oregon Medical Board" or complete the credit card information on the last page.

2) If your application requires special review and final Board approval prior to licensure *(please see Acupuncture Licensure Overview www.oregon.gov/omb),* the following deadlines will apply to you:
   - o Application Filing Deadline: October 24, 2008
   - o File Completion Deadline: November 7, 2008
   - o Next Acupuncture Advisory Committee Meeting: December 5, 2008
   - o Next Oregon Medical Board Meeting: January 9, 2009

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

IF PREVIOUSLY HELD OREGON LICENSE, SHOW ❒ **LIMITED LICENSE #** **LL**_____
❒ **UNLIMITED LICENSE #** _____

FULL LEGAL NAME (last, first, middle)	
OTHER NAMES USED (last, first, middle)	SOCIAL SECURITY NUMBER
CURRENT MAILING ADDRESS (Street, City, State, Zip) **NOTE: This is the address that will print on your Certificate of Registration and the address to which your certificate will be mailed. This address is available to the public.**	Area code Phone no.
OREGON BUSINESS ADDRESS (Required) (Street, City, State, Zip)	Area code Phone no.
OREGON RESIDENCE ADDRESS (Street, City, State, Zip)	Area code Phone no.
INSTITUTION AT WHICH YOU WILL BE TEACHING IN OREGON ☐ Oregon Colllege of Oriental Medicine (OCOM) ☐ National College of Natural Medicine (NCNM)	E-MAIL ADDRESS
NAME AND LOCATION OF ACUPUNCTURE SCHOOL/TRAINING PROGRAM FROM WHICH YOU GRADUATED	DIPLOMA DATE
ARE YOU CERTIFIED BY THE NCCAOM? ☐ **YES** ☐ **NO**	IF YOU ARE NCCAOM CERTIFIED, CERTIFICATION: DATE _____ NUMBER _____

ALL ACUPUNCTURE LICENSES HELD

State/Province/Country	Date Issued	Number	Current Yes	Current No

EDUCATION, EMPLOYMENT, AND OTHER ACTIVITIES

List all activities (employment, school, vacation, unemployment, moving, etc.) for the past ten (10) years. **DO NOT leave a gap of more than one month** or you will be asked to provide written clarification. **Dates must be complete (month and year).** Resumes are not accepted.

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

PERSONAL HISTORY QUESTIONS

Acupuncture Limited License Visiting Professor

Review the Application Instructions when completing this section.

The answers to some of these questions may be exempt from public disclosure under ORS 192.505(2), the Oregon Public Records Law, unless a party seeking disclosure, by clear and convincing evidence, shows that disclosure would not be an unreasonable invasion of privacy and that the public interest requires disclosure in the particular instance. The answers to these questions may be considered by the Board and may be disclosed in any contested case hearing or appeal of a licensing decision based upon them.

Answer all questions. If you answer "yes" to any of the questions, you must provide a complete explanation of the event(s) or condition(s), including dates, names, addresses, circumstances, and results. Attach a written explanation or enter a written explanation on page 4.

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

CATEGORY I

YES	NO	
☐	☐	1. Have you ever engaged in the unlicensed practice of any health care profession when you were required by law to have a license?
☐	☐	2. Have you ever failed a state or national examination or any portion of an examination to qualify for a state license to practice a health care profession?
☐	☐	3. Have you ever been asked to and/or permitted to withdraw an application for licensure, for credentialing, or for certification with any board, agency or institution?
☐	☐	4. Has any state licensing board refused to issue, refused to renew, or denied you a license to practice?
☐	☐	5. Have you ever had any disciplinary or adverse action imposed against any professional license or certification, or were you ever denied a professional license or certification, or have you entered into any consent agreement, stipulated order or settlement with any regulatory Board or certification agency; or have you ever been notified of any complaints or investigations related to any license or certification?
☐	☐	6. Have you ever been denied approval to prescribe controlled substances, or been charged with a violation of federal or state narcotic laws, or been asked to surrender your DEA number?
☐	☐	7. Have you ever been arrested, convicted of, or pled guilty or "nolo contendere" to ANY offense in any state in the United States or any foreign country, other than minor traffic violations?
☐	☐	8. Have you ever been contacted by or asked to make a response to any governmental agency in any jurisdiction regarding any criminal or civil investigation of which you are the subject, whether or not a charge, claim or filing with a court actually occurred?
☐	☐	9. Are you aware of any current, proposed, impending or threatened civil or criminal action against you? *This includes whether or not a claim, charge or filing was actually made with a court*.
☐	☐	10. Have you ever entered into any formal, informal, out-of-court or confidential settlement to deter, prevent, or settle a claim, lawsuit, letter of intent to sue, and/or criminal action? *This includes whether or not a claim, charge or filing was actually made with a court.*
☐	☐	11. Has any award, settlement or payment of any kind ever been made by you or on your behalf to resolve a malpractice claim, even if it was not required to be reported to the National Practitioner Data Bank (NPDB); or have you ever been notified in any manner that any such claim is proposed, pending or threatened, whether or not a claim, charge or filing was actually made with a court?
☐	☐	12. Have you interrupted the practice of your health care profession for one year or more, or ceased the practice of your specialty?

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

☐ ☐ 14. Have you ever had privileges denied, reduced, restricted, suspended, revoked, terminated or have you been placed on probation, been subject to staff disciplinary action or non-renewal of an employment contract, or been requested to voluntarily resign or suspend your privileges while under investigation from a hospital, clinic, surgical center, or other medically related employment; or have you ever been notified that such action or request is pending or proposed? Have you been allowed to withdraw your staff privileges from a hospital or 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 # _____

IDENTIFICATION

SIGN AND DATE FRONT OF PHOTO AND ATTACH IT BELOW

Gender: _____

Height: (ft. & in.) _____

Weight: (lbs.) _____

Hair Color: _____

Eye Color: _____

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

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

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

RELEASE/AFFIDAVIT OF APPLICANT

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

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates, business associations (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign), which includes state health licensing 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 acupuncture 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 acupuncture license in the state of Oregon.

_____
Sign your name in presence of a Notary

This portion to be completed by notary

Subscribed and sworn to before me on _____

Notary Signature _____

Notary Public for _____ Commission expires _____

Notary Seal or Imprint

CREDIT CARD INFORMATION ON NEXT PAGE

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