

Above Space for Official Use Only
 Key Code
 1041 1042 1043 1045
 \$185 \$185 \$185 \$185

LL Issued _____ FROM _____ TO _____ LICENSE # LL _____

Type 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, 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.

Check Applicable Box. Must be correct for accurate processing.

- | | | | |
|------------|---------------------------------------|------------|---|
| KEY | | KEY | |
| 1043 | <input type="checkbox"/> POSTGRADUATE | 1045 | <input type="checkbox"/> MEDICAL FACULTY |
| 1041 | <input type="checkbox"/> FELLOW | 1042 | <input type="checkbox"/> VISITING PROFESSOR |

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

1. IF YOU HAVE PREVIOUSLY HELD OREGON LICENSE, SHOW:	
<input type="checkbox"/> LIMITED LICENSE #	<input type="checkbox"/> UNLIMITED LICENSE #
2. NAME: LEGAL NAME	
Last Name	First Name Middle Name <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> DPM
3. OTHER NAMES USED:	
Last Name	First Name Middle Name <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> DPM
4. CURRENT MAILING ADDRESS: (IF APPLICABLE)	
Street	5. PHONE NUMBER:
City State Zip	
6. OREGON PRACTICE/TRAINING ADDRESS:	
Street	7. PHONE NUMBER:
City State Zip	
8. DO YOU WANT YOUR PRACTICE ADDRESS ON THE OREGON MAILING WEBSITE:	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
9. OREGON RESIDENCE ADDRESS:	
Street	10. PHONE NUMBER:
City State Zip	

12. E-MAIL ADDRESS:		13. SOCIAL SECURITY NUMBER	
14. SPECIALTY FOR TRAINING/PRACTICE IN OREGON:		15. ECFMG #:	16. DATE ISSUED (MM/DD/YY)
17. NAME OF MEDICAL/OSTEOPATHIC/PODIATRIC SCHOOL:		18. DEGREE (MM/DD/YY)	
19. LOCATION OF MEDICAL/OSTEOPATHIC/PODIATRIC SCHOOL City, State / Country			

20. I HAVE COMPLETED THE FOLLOWING EXAMINATIONS OR SOON WILL BE COMPLETING THEM:

<input type="checkbox"/> USMLE	<input type="checkbox"/> Step 1	<input type="checkbox"/> Step 2	<input type="checkbox"/> Step 3
<input type="checkbox"/> National Board of Medical Examiners (MD)	<input type="checkbox"/> Part I	<input type="checkbox"/> Part II	<input type="checkbox"/> Part III
<input type="checkbox"/> FLEX Examination	<input type="checkbox"/> Day I	<input type="checkbox"/> Day 2	<input type="checkbox"/> Day 3 -OR- <input type="checkbox"/> Component 1 <input type="checkbox"/> Component 2
National Board of Osteopathic Examiners (DO)			
<input type="checkbox"/> National Board of Podiatric Examiners (DPM)			
<input type="checkbox"/> Medical Council of Canada (LMCC)			

21. ALL LICENSES APPLIED FOR: (even if not current) State/Province/Country	RESULTS Explain			LICENSE/CERTIFICATE				PERM OR TEMP	LICENSE OBTAINED BY			CURRENT	
	Granted	Denied	Pending	Issued MM/DD/YY	NUMBER				USMLE	FLEX	RECIP	NB	YES

22. 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)	TRAINING LEVELS	SPECIALTY	NAME OF INSTITUTION OR PLACE OF PRACTICE AND MAILING ADDRESS	BEGINNING DATE MM/DD/YY	ENDING DATE MM/DD/YY
EXAMPLE					
Internship	PG1	Rotating	Yale Univ. Sch Med., 333 Cedar St., New Haven, CT 06520	07/01/97	06/30/98
Residency	PG 2 and 3	Internal Med	Yale Univ. Sch Med., 333 Cedar St., New Haven, CT 06520	07/01/98	06/30/00
Private Practice - Group		Internal Med	10 Oak Grove Rd, Stamford, CT 06907	07/01/00	11/30/06

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

- | YES | NO | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Do you hold, or have you ever held, any licenses to practice another health care profession? |
| <input type="checkbox"/> | <input type="checkbox"/> | 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? <i>If you ever failed a portion of a licensing examination you must answer "yes" even if you later passed the examination.</i> |
| <input type="checkbox"/> | <input type="checkbox"/> | 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? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Has any state licensing board refused to issue, refused to renew or denied you a license to practice? |
| <input type="checkbox"/> | <input type="checkbox"/> | 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? |
| <input type="checkbox"/> | <input type="checkbox"/> | 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? |
| <input type="checkbox"/> | <input type="checkbox"/> | 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? |
| <input type="checkbox"/> | <input type="checkbox"/> | 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? |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Are you aware of any current, proposed, impending or threatened civil or criminal action against you? <i>This includes whether or not a claim, charge or filing was actually made with a court.</i> |
| <input type="checkbox"/> | <input type="checkbox"/> | 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? <i>This includes whether or not a claim, charge or filing was actually made with a court.</i> |
| <input type="checkbox"/> | <input type="checkbox"/> | 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? <i>(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.)</i> |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. Have you interrupted the practice of your health care profession for one year or more, or ceased the practice of your specialty? |
| <input type="checkbox"/> | <input type="checkbox"/> | 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? |
| <input type="checkbox"/> | <input type="checkbox"/> | 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 you need more space, please use the form at: http://egov.oregon.gov/OMB/MD-DO_Application/Personal_History_Explan_Form.pdf.

Category _____ Question # _____

Category _____ Question # _____

Category _____ Question # _____

Category _____ Question # _____

PERSONAL IDENTIFICATION

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.**

1. **GENDER:** _____
2. **HEIGHT:** (ft. & in.) _____
3. **WEIGHT:** (lbs.) _____
4. **HAIR COLOR:** _____
5. **EYE COLOR:** _____
6. **DATE OF BIRTH:** _____
(Month) (Day) (Year)
7. **PLACE OF BIRTH:** _____
(City) (State) (Country)

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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