# Affidavit for Reactivation of Oregon Medical License MD/DO/DPM

Revised 4/2016

The Board strongly recommends that this application for licensure reactivation be completed by the licensee. Any information incorrectly supplied will be considered to have been supplied by the licensee.

| **FULL LEGAL NAME** Last name (Jr., II, etc.) | First Name | Middle Name | ☐ MD ☐ DO ☐ DPM |
|---|---|---|---|
| **OTHER NAMES YOU HAVE BEEN KNOWN BY** Last Name | First Name | Middle Name | |

| **CURRENT PRACTICE STREET ADDRESS** | City | State | Zip |
|---|---|---|---|
| **CURRENT RESIDENCE STREET ADDRESS** | City | State | Zip |
| **CURRENT OTHER STREET ADDRESS** (if applicable) | City | State | Zip |

**Please indicate your mailing address:** ☐ Practice ☐ Residence ☐ Other

| **PRACTICE TELEPHONE NUMBER** | **RESIDENCE TELEPHONE NUMBER** | **OTHER TELEPHONE NUMBER** |
|---|---|---|
| **E-MAIL ADDRESS** | | **SOCIAL SECURITY NUMBER (LAST 4 DIGITS)** |

**PROPOSED OREGON PRACTICE INFORMATION**

| Hospital/Clinic/Medical group | Primary Specialty | Proposed Start Date | Dispensing Address? ☐ YES ☐ NO |
|---|---|---|---|
| Proposed Practice Street Address | City | State | Zip |

**INDICATE YOUR REQUESTED LICENSE STATUS:**

- ☐ **ACTIVE** status -- Practicing in Oregon or within 100 miles of the Oregon border
- ☐ **LOCUM TENENS** status -- Non-Oregon resident and completing locum tenens assignments only
- ☐ **TELERADIOLOGY** status -- Reading radiological images for Oregon patients from an out-of-state address
- ☐ **TELEMEDICINE** status – Practicing outside of Oregon and treating Oregon patients via electronic means
- ☐ **TELEMONITORING** status – Practicing outside of Oregon and monitoring intraoperative data for Oregon patients via a telemedicine link
- ☐ **EMERITUS** status – Practicing in Oregon for no pay or any other type of compensation

**SPECIALTY BOARD CERTIFICATION** List any certifications or re-certifications you have obtained for any specialty boards

| **SPECIALTY BOARD** | **CERTIFICATION DATE** (mm/dd/yy) | **RE-CERTIFICATION DATE** (mm/dd/yy) |
|---|---|---|
| **SPECIALTY BOARD** | **CERTIFICATION DATE** (mm/dd/yy) | **RE-CERTIFICATION DATE** (mm/dd/yy) |
| **SPECIALTY BOARD** | **CERTIFICATION DATE** (mm/dd/yy) | **RE-CERTIFICATION DATE** (mm/dd/yy) |

**CHRONOLOGY OF ACTIVITIES**. List all health related activities including, training, employment, temporary or granted hospital/staff privileges, locum tenens assignments, volunteer work, and account for all periods of time from the date of the last license renewal (ex. 1/1/XX) up to and including the present date. There should be no gaps of time in chronology. Please note: A curriculum vitae is NOT acceptable. Attach a separate sheet if necessary.

| **TYPE OF ACTIVITY** (employment, vacation, privileges, etc.) | **PRIVILEGE STATUS** (granted, pending, denied, restricted) | **SPECIALTY** | **NAME OF INSTITUTION OR PLACE OF PRACTICE AND MAILING ADDRESS** | **BEGINNING DATE** (mm/dd/yy) | **END DATE** (mm/dd/yy, or **leave blank** for present) |
|---|---|---|---|---|---|
| **EXAMPLE** Employment- Surgeon | Granted | General Surgery | General Hospital, 100 Main St, Anytown, OR 91234 | 01/01/14 | |
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**PERSONAL HISTORY QUESTIONS FOR REACTIVATION**

Answer all questions in both Category I and II. Category I will help the Board determine if you meet the essential eligibility requirements for registration. Category II will help the Board determine if you are qualified to practice safely and competently, with or without reasonable modification.

If you answer "yes" to any of the questions, you must submit a complete explanation of the event(s) or condition(s), including dates, names, addresses, circumstances, and results. If you need more space than is provided here, you may use the Personal History Explanation Form.

NOTE: Answer all of the following questions completely and honestly. Omissions or false, misleading or deceptive information in applying for or procuring a license, registration or reactivation in Oregon is a violation of the Medical Practice Act and is grounds for a fine and further disciplinary action by the Board, including denial, suspension or revocation of licensure. Such acts are reported to the National Practitioner Data Bank and/or appropriate national professional credentialing organizations.

## CATEGORY I

The answers to many of these questions are exempt from public disclosure under state or federal law. 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.

YES NO

☐ ☐ 1. Do you hold, or have you ever held, any licenses to practice another health care profession?

YES NO

☐ ☐ 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. Regardless of the outcome, have you been denied approval to prescribe controlled substances, or been subject to an inquiry or charged with a violation of federal or state controlled substance laws, or been asked to surrender your DEA number?

☐ ☐ 7. Have you ever been arrested, convicted of, or pled guilty or "nolo contendere" (no contest) to ANY offense in any state in the United States or any foreign country, other than minor traffic violations? Matters in which you were pardoned and/or diverted, or the conviction was deferred, set aside, or expunged must be disclosed, excluding expunged juvenile records.

☐ ☐ 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 the 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. During medical school or postgraduate training, were you ever subject to an action for any academic, clinical or professional concerns, including actions such as counseling, warning, remediation, probation, restriction, suspension, termination, or request to voluntarily resign?

YES NO

☐ ☐ 14. Regarding your medically related employment, have you ever had privileges denied, reduced, restricted, suspended, revoked or terminated; or have you ever been subject to disciplinary action including but not limited to probation; or have you been subject to non- renewal of an employment contract; or have you been asked to voluntarily resign or voluntarily suspend your privileges; or have you been under investigation by a hospital, clinic, surgical center, or other medically related employer; or have you been notified that such action or request is pending or proposed?

## CATEGORY II

The answers to Category II questions are exempt from public disclosure under state and federal law. 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.

**The Board encourages early identification and appropriate treatment of physical, mental, or emotional conditions and substance use disorders. If applicable, the following questions should be read to include the clause, "Other than what is already known and in compliance with the recommendations of the Oregon Health Professionals' Services Program (HPSP)."**

YES NO

☐ ☐ 1. Within the past five years, have you entered into a program other than the Oregon Health Professionals' Services Program (HPSP) for evaluation, monitoring, or treatment for ANY issue in lieu of or as a condition of resolving a matter before a health care program or facility or a regulatory or licensing board or has such action been pending or proposed? "Issue" includes, but is not limited to, substance use, communication, or boundary issues.

☐ ☐ 2. Do you currently have, 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?

☐ ☐ 3. Within the past 5 years, have you been admitted to any hospital or other treatment facility for any physical, mental, or emotional condition or substance use disorder which impaired or does impair your ability to practice your health care profession safely and competently?

☐ ☐ 4. Do you currently engage in the excessive or habitual use of alcohol or drugs or 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? "Excessive" as used in this question includes, but is not limited to, 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 drug or of an alcohol level above .08% BAC? This does not include those drugs taken by you for 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.

**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 there is not enough space, attach a signed and dated "Addendum."

Category ___ Question #___

| **DATE OF BIRTH** (mm/dd/yy) | **PLACE OF BIRTH** City, State, or Country | **ATTACH (TAPE) PHOTOGRAPH HERE.** Sign your name in ink and show date taken on back of photograph. |
|---|---|---|
| **PHYSICAL DESCRIPTION** Height Weight / Eyes / Hair | | **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"x3" and no smaller than 2"x2". 4. Taken within 90 days prior to filing this application. 5. Signed in ink showing date taken on back of photograph. |
| Before submission, it is suggested that you make a copy for your records.<br><br>Once processed by the Board you will receive one-time correspondence regarding the status of your application. You may review the status of your application anytime by visiting the On-line Status Report (OSR): https://techmedweb.omb.state.or.us/Clients/ORMB/Private/OnlineServices/Login.aspx<br><br>Our Licensing Call Center is here to help<br>9 AM to 12 PM and 1PM to 3PM M – F<br>omb.help@state.or.us<br>Phone: 971-673-2700<br>Toll-free in Oregon: 1-877-254-6263 | | |

## RELEASE/AFFIDAVIT OF APPLICANT FOR REACTIVATION

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

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 make any omissions or furnish any false, misleading, or deceptive statements or information in this application, I hereby agree that such act is a violation of the Medical Practice Act and is grounds for a fine and the denial, suspension, or revocation of my license to practice medicine or acupuncture 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 _____

Please mail original, completed, notarized affidavit to: OMB, 1500 SW 1st Ave, Suite 620, Portland, OR 97201