Verification of Health Related License

PA/AC Licensure

Revised 07/2021

INSTRUCTIONS TO APPLICANT: Complete UPPER portion of form and send directly to the jurisdiction from which are requesting verification. Jurisdiction is to complete LOWER portion of the form and return **DIRECTLY** to the OREGON MEDICAL BOARD.

Last Name	First Name	Middle Name

Other Names you have been known by	DOB (mm/dd/yy)	Last 4 SSN

Street Address, City, State, Zip Code

Type of License Granted	License Number	Date License Granted (mm/dd/yy)

I authorize the release of any information, favorable or otherwise regarding myself to the Oregon Medical Board. By signing this document, I release the jurisdiction and its representatives of liability for providing information to the Board.

Signature _____ Date _____

INSTRUCTIONS TO JURISDICTION: Please complete this form, sign and return it to the Board at the address below in an institution envelope. Official self-generated verification forms with the same information will also be accepted. **Faxed responses will NOT be accepted**.

Licensee Name (First, Middle, Last)

License Number	Type of Licensure	Current Status	Date Issued (mm/dd/yy)	Date Expired (mm/dd/yy)

Please check the box that applies:

I certify that the above license issued in this state or jurisdiction has never been suspended or revoked and that there has never been any disciplinary action taken against the holder of this license. ☐

OR

☐ I understand I am not required to provide the following information, and I ask that the following responses be kept confidential.
If requested here, the Board will grant confidentiality for the below information.

The following action has been taken against this licensee. **Please explain. Attach any supporting legal documents and additional pages if necessary.** ☐

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Signature of Official _____ Affix Seal Here

Print Name _____ Date: _____

Title _____

Jurisdiction/Licensing Agency _____

Mailing Street _____

City _____ State _____ Zip _____

Phone _____

E-mail _____