Verification of Education

PA/AC Licensure

Revised 06/2022

INSTRUCTIONS TO APPLICANT: Complete UPPER portion of form and send directly to the Dean of the educational institution. School 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

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

Signature ______________________________ Date ______________

INSTRUCTIONS TO SCHOOL: Please complete this form, sign and return it to the Board at the address below in an institution envelope. **Faxed responses will NOT be accepted.**

	FROM (mm/dd/yy)	TO (mm/dd/yy)	DIPLOMA ISSUE DATE (mm/dd/yy)
Dates of Attendance:	____________	____________	____________

Unusual Circumstances: The following apply to unusual circumstances that occurred during any part of the applicant's education. Please check the appropriate response. **If you answer "Yes" to any of these questions, please provide an explanation on page 2 of this form and attach copies of any documentation.**

☐ 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.

1.	Was the applicant's [education/training] extended beyond the originally anticipated completion date? Extensions may include the applicant's voluntary leave of absence, required remediation, or any other action or event that extended the applicant's [education/training].	☐ YES	☐ NO
2.	Was the applicant ever subject to an official action, including but not limited to probation, discipline, suspension, restriction, limitation of privileges, termination, or request to voluntarily resign?	☐ YES	☐ NO
3.	Were there any concerns regarding the applicant's knowledge base, clinical skills, medical judgment, professionalism, or ethics?	☐ YES	☐ NO
4.	Were there any concerns regarding possible impairment in the applicant's ability to safely practice their profession? Impairment may be caused by physical or mental illness or substance use.	☐ YES	☐ NO

Signature of Official ______________________________ Affix School Seal Here

Print Name ____________________ Date: ____________

Title ______________________________

School Name ______________________________

Mailing Street ______________________________

City ______________ State ______ Zip ____________

Phone ______________________________

E-mail ______________________________

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Please use the spaces below to provide an explanation of any "Yes" response to the questions on page 1 of this form. **Attach any supporting documentation and additional pages if necessary.**

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2. Was the applicant ever subject to an official action, including but not limited to probation, discipline, suspension, restriction, limitation of privileges, termination, or request to voluntarily resign?

3. Were there any concerns regarding the applicant's knowledge base, clinical skills, medical judgment, professionalism, or ethics?

4. Were there any concerns regarding possible impairment in the applicant's ability to safely practice their profession? Impairment may be caused by physical or mental illness or substance use.