Verification of Internship, Residency, Fellowship Training

MD/DO/DPM Licensure

Revised 06/2022

INSTRUCTIONS TO APPLICANT: Complete UPPER portion of form and send directly to any hospital/institution where training has been served. Training hospital/institution 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

Hospital/Institution name at the time of training | Dates of training: From (mm/dd/yy) To (mm/dd/yy)

I authorize the release of information, favorable or otherwise, from my postgraduate training program listed above, 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 PROGRAM DIRECTOR: 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.** Please affix the seal of the hospital/institution; if hospital/institution does not have a seal, please so indicate.

Training	Postgraduate Level of Training						Specialty Department	FROM (mm/dd/yy)	TO (mm/dd/yy)
Internship	☐ PG 1	☐ PG 2	☐ PG 3	☐ PG 4	☐ PG 5	☐ PG 6			
Residency	☐ PG 1	☐ PG 2	☐ PG 3	☐ PG 4	☐ PG 5	☐ PG 6			
Residency	☐ PG 1	☐ PG 2	☐ PG 3	☐ PG 4	☐ PG 5	☐ PG 6			
Residency	☐ PG 1	☐ PG 2	☐ PG 3	☐ PG 4	☐ PG 5	☐ PG 6			
Residency	☐ PG 1	☐ PG 2	☐ PG 3	☐ PG 4	☐ PG 5	☐ PG 6			
Fellowship	☐ PG 1	☐ PG 2	☐ PG 3	☐ PG 4	☐ PG 5	☐ PG 6			

Unusual Circumstances: The following apply to unusual circumstances that occurred during any part of the applicant's training. Please check the appropriate response. **If you answer yes to any of these questions, please enclose 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

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Program Director's Signature ______________________ Affix Seal Here

Print Name ______________________ Date ____________

Specialty Department ______________________

Facility Name ______________________

Mailing Street ______________________

City ______________ State ______ Zip ____________

Phone ______________________

E-mail ______________________

Please use the spaces below to provide an explanation of any "Yes" response to the questions on page 1 of this form. **Attach 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.

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