Verification of Medical Education

MD/DO/DPM Licensure

Revised 07/2021

INSTRUCTIONS TO APPLICANT: Complete UPPER portion of form and send directly to the Dean of the medical, osteopathic, or podiatric school. School is to complete LOWER portion of the form and return **DIRECTLY** to the OREGON MEDICAL BOARD. The Dean shall also include a Dean's Letter of Recommendation with narrative comments concerning performance as a medical student.

Last Name | First Name | Middle Name

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

Institution name at the time of training | Dates of Attendance: From (mm/dd/yy) | To (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 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. Please also include a Dean's Letter of Recommendation, written during medical school, to include narrative comments concerning performance as a medical student. **Faxed responses will NOT be accepted.**

Name of Applicant (First, Middle, Last) | Date of Degree (mm/dd/yy) | Degree Obtained: ☐ MD ☐ DO ☐ DPM

☐ YES ☐ NO Was school accredited by the Liaison Committee of Medical Education, the American Osteopathic Association, or the Committee on the Accreditation of the Canadian Medical Schools at the time the applicant graduated?

☐ YES ☐ NO If no, did the applicant complete all courses by physical on-site attendance?

Dates of Attendance (Show month/day/year for all dates)		FROM (mm/dd/yy)	TO (mm/dd/yy)		FROM (mm/dd/yy)	TO (mm/dd/yy)
	1st year			5th year		
	2nd year			6th year		
	3rd year			7th year		
	4th year			8th year		

TRANSFER STUDENT

FROM (mm/dd/yy)	TO (mm/dd/yy)	Name of School & Location

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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

LEAVE OF ABSENCE/REPEATED YEAR(S)		
FROM (mm/dd/yy)	TO (mm/dd/yy)	Dates & Reason(s)

Signature of Official ______________________ Affix Seal Here

Print Name ______________________ Date __________

Title ______________________

Name of School at GRADUATION ______________________

Name of School at PRESENT ______________________

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.