



OHSU Physician Re-Entry Program Preliminary Application

Practitioner General Information

Last Name: _____ First: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ E-Mail: _____

DOB: _____ Gender: _____ Years out of practice: _____

Principal Clinical Specialty: _____

SSN: _____ NPI: _____ DEA: _____

Medical Licenses *Please attach additional sheets, if necessary.*

Current License

State/Country: _____ Number: _____

Active: yes/no If not active, please explain: _____

Past License(s)

State/Country: _____ Number: _____

Type: _____ Expiration Date: _____

Status: _____

Board Certification/ Recertification *This section does not apply to licensure*

List all current and past certifications. Please attach additional sheets, if necessary.

If not currently board certified, describe your intent for certification, if any and dates of previous testing and/or intended future testing for certification below. Please attach additional sheets, if necessary.

Name and Address of Issuing Board: _____

Specialty: _____

Date Certified/ Recertified: _____ Expiration Date (if any) _____

Name and Address of Issuing Board: _____

Specialty: _____

Date Certified/ Recertified: _____ Expiration Date (if any) _____

If expired, please explain: _____

Undergraduate Education *Please attach additional sheets, if necessary.*

Complete School Name: _____

Degree Received: _____

From: _____ To: _____ Major: _____

City: _____ State: _____

Graduate Education *Please attach additional sheets, if necessary.*

Complete School Name: _____

Degree Received: _____

From: _____ To: _____ Major: _____

City: _____ State: _____ Zip: _____

Medical Education *Please attach additional sheets, if necessary.*

Complete Medical School Name and Address: _____

City: _____ State: _____ Zip: _____

Phone number: _____ Fax, if available: _____

From: _____ To: _____ Date of completion (mm/yy): _____

If not completed in four years, please explain: _____

Residency *Please attach additional sheets, if necessary.*

Specialty: _____

Complete Institution Name and Address: _____

City: _____ State: _____ Zip: _____

Phone number: _____ Fax, if available: _____

From: _____ To: _____ Date of completion (mm/yy): _____

If additional time taken to complete, please explain: _____

Fellowship *Please attach additional sheets, if necessary.*

Specialty: _____

Complete Institution Name and Address: _____

City: _____ State: _____ Zip: _____

Phone number: _____ Fax, if available: _____

From: _____ To: _____ Date of completion (mm/yy): _____

Did you complete the program: _____

Professional Practice/ Work History *Please attach additional sheets, if necessary*

**A curriculum vitae is not sufficient*

** Please explain any gaps greater than 3 months.*

Name of current practice/ employer: _____

Complete address: _____

City: _____ State: _____ Zip: _____

Phone number: _____ Fax, if available: _____

From: _____ To: _____ Contact name: _____

Description of responsibilities: _____

Name of previous practice/ employer: _____

Complete address: _____

City: _____ State: _____ Zip: _____

Phone number: _____ Fax, if available: _____

From: _____ To: _____ Contact name: _____

Description of responsibilities: _____

Name of previous practice/ employer: _____

Complete address: _____

City: _____ State: _____ Zip: _____

Phone number: _____ Fax, if available: _____

From: _____ To: _____ Contact name: _____

Description of responsibilities: _____

ATTESTATION QUESTIONS – This section to be completed by the Practitioner.

Modification to the wording or format of these Attestation Questions will invalidate the application.

Please answer the following questions “yes” or “no”. If your answer to any of the following questions is “yes”, please provide details and reasons, as specified in each question, on a separate sheet. **Please sign and date each additional sheet.**

A.	Has your license, certification, or registration to practice your profession, Drug Enforcement Administration (DEA) registration, or narcotic registration/certificate in any jurisdiction ever been denied, limited, suspended, revoked, not renewed, voluntarily or involuntarily relinquished, or subject to stipulated or probationary conditions, or have you ever been fined or received a letter of reprimand or is any such action pending or under review?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
B.	Have you ever been suspended, fined, disciplined, or otherwise sanctioned, restricted or excluded for any reasons, by Medicare, Medicaid, or any public program or is any such action pending or under review?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
C.	Have you ever been denied clinical privileges, membership, contractual participation or employment by any health care related organization, or have clinical privileges, membership, participation or employment at any such organization ever been placed on probation, suspended, restricted, revoked, voluntarily or involuntarily relinquished or not renewed, or is any such action pending or under review?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
D.	Have you ever surrendered clinical privileges, accepted restrictions on privileges, terminated contractual participation or employment, taken a leave of absence, committed to retraining, or resigned from any health care related organization while under investigation or potential review?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
E.	Has an application for clinical privileges, appointment, membership, employment or participation in any health care related organization ever been withdrawn on your request prior to the organization’s final action?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
F.	Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, limited, voluntarily or involuntarily relinquished or not renewed, or is any such action pending or under review?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
G.	Have you ever had board certification revoked?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
H.	Have you ever been the subject of any reports to a state or federal data bank or state licensing or disciplinary entity?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
I.	Have you ever been charged with a criminal violation (felony or misdemeanor)?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
J.	Do you presently use any illegal drugs?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
K.	Do you now have, or have you recently had, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or is reasonably likely to affect your current ability to practice, with or without reasonable accommodation, the privileges requested? If reasonable accommodation is required, please specify the accommodation(s) required on a separate sheet.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
L.	Have any professional liability claims or lawsuits ever been filed against you? If yes, please complete Attachment A for each past or current claim and/or lawsuit.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
M.	Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

I certify the information in this entire application is complete, current, correct, and not misleading. I understand and acknowledge that any misstatements in, or omissions from this application will constitute cause for denial of my application or summary dismissal or termination of my participation in the program. In the case of dismissal, there will be no refund of fees paid. A photocopy of this application, including this attestation, the authorization and release and any or all attachments has the same force and effect as the original. I have reviewed this information on the most recent date indicated below and it continues to be true and complete. While this application is being processed, I agree to update the information originally provided in this application should there be any change in the information.

Signature: _____ **Date:** _____

Please respond to the following questions on additional pages. Attach answers on 1-2 pages

1. Please describe the events/ reasons that led you to discontinue clinical practice.
2. Please describe the type and amount of CME you have participated in during your period of clinical inactivity, be specific.
3. Please describe any other methods you have used to stay engaged in the practice of medicine.
4. Why do you wish to re-enter clinical practice?
5. Why do you want to enroll in the OHSU re-entry program? What do you hope to accomplish in the reentry program?
6. What specialty and scope of practice do you wish to return to?