



REQUEST FOR VERIFICATION OF EMPLOYMENT

Physician Name: _____
Date of Birth: _____
Dates of Employment: From: _____ To: _____
Specialty: _____

School of Medicine

Office of the Dean

Mail code: L102
3181 SW Sam Jackson Park Rd.
Portland, Oregon 97239-3098
tel 503 494-8220
fax 503 494-3400

Office of Admissions

tel 503 494-2998

Continuing Medical Education

Mail code: L602
tel 503 494-8700
fax 503 494-0392

Development and Alumni Relations

tel 503 494-0723

Education and Student Affairs

tel 503 494-8228

Graduate Medical Education

Mail code: L579
tel 503 494-8652
fax 503 494-8513

Graduate Studies

tel 503 494-6222

We are verifying the credentials of the above physician who has indicated that he/she was employed at your institution in the specialty listed above.

Enclosed is a copy of the Release/Authorization form authorizing release of information to Oregon Health & Science University. Thank you for your assistance.

Reply to: Graduate Medical Education - OHSU
3181 SW Sam Jackson Park Road, L579
Portland, OR 97239

Please Verify:

Dates of employment: From _____ To _____

Name of Specialty: _____

Was the physician in good standing throughout their employment?

Yes No If no, explain _____

Are you aware of any physical, mental, or chemical dependency conditions which could interfere with the ability to practice the designated specialty?

Yes No If yes, describe _____

Are you aware of any disciplinary action taken by your institution or others?

Yes No If yes, describe _____

Additional Comments:

Printed Name _____ Title _____

Signature _____ Date _____

Name of institution _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Fax # _____

AUTHORIZATION AND RELEASE OF INFORMATION FORM

Modified Releases Will Not Be Accepted

By submitting this authorization, I understand and agree to the following:

1. I understand and acknowledge that, as an applicant for residency/fellowship at the designated Hospital(s) and/or participation status with healthcare-related organization(s) indicated on this application (verification of residency/fellowship), I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and other qualifications. In this application, I have provided information on my qualifications, professional training and experience, prior and current licensure, Drug Enforcement Agency registration and history, and applicable certifications. I have provided peer reference familiar with my professional competence and ethical character, if requested. I have disclosed and explained any past or pending professional corrective action, licensure limitations or related matter, if any. I have reported my malpractice claims history, if any, and have attached or will provide a copy of a current certificate of professional liability coverage.
2. I further understand and acknowledge that the healthcare-related organization(s) or residency/fellowship program will investigate the information in this application. By submitting this application, I agree to such investigation and to the disciplinary reporting and information exchange activities of the residency/fellowship and healthcare related organization(s) as a part of the verification process.
3. I authorize all individuals, institutions, entities of other hospitals or institutions with which I have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status, to consult with the designated residency/fellowship programs and healthcare-related organization(s), their staffs and agents.
4. I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to carry out the training program requirements. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews, if required or requested.
5. I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with investigating and evaluating my application and qualifications, and I waive all legal claims against any representative of the residency/fellowship and healthcare-related organization(s) or their respective agent(s) who acts in good faith and without malice in connection with the investigation of this application.
6. I understand and agree that the authorizations and releases given by me herein shall be valid so long as I am an applicant for or have status as resident/fellow at the healthcare-related organization(s) designated herein, unless revoked by me in writing.
7. For residency/fellowship positions, I acknowledge that I have been informed of, and hereby agree to abide by, the medical staff by-laws, rules, regulations and policies.
8. I agree to exhaust all available procedures and remedies as outlined in the bylaws, rules, regulations, and policies, and/or contractual agreements of the residency/fellowship or healthcare-related organization(s) where I am training.
9. I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application.

Printed Name: _____

Signature _____ Date _____

I grant permission for the release of the residency/fellowship information contained in this application to the following healthcare-related organization(s):

Modification to the wording or format will invalidate this authorization.