



Verification of Podiatric Hospital Privileges to Perform Ankle Surgery DPM Licensure

Revised 07/2015

INSTRUCTIONS TO APPLICANT: Complete UPPER portion of form and send directly to any hospital where employed or where hospital staff membership has been requested and where ankle surgeries have been performed. Hospital 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	Date of Birth (mm/dd/yy)	Last 4 Digits of Social Security Number
Hospital name at the time of association		Dates of Association: FROM (mm/dd/yy) TO (mm/dd/yy)
Type of Association: <input type="checkbox"/> Employee <input type="checkbox"/> Staff Member <input type="checkbox"/> Locum Tenens <input type="checkbox"/> Emergency Room <input type="checkbox"/> Other: _____		

I authorize the release of all pertinent information, favorable or otherwise, to the Oregon Medical Board. By signing this document, I release the Hospital and its representatives of liability for providing information to the Board.

Signature _____ Date _____

INSTRUCTIONS TO HOSPITAL: Please complete this form, sign and return it to the Board at the address below in an institution envelope. Please affix the seal of the hospital; if hospital does not have a seal, please so indicate. **Faxed responses will NOT be accepted.**

Type of Association:
 Employee
 Staff Member
 Locum Tenens
 Emergency Room
 Other: _____

Hospital name at the time of association _____ Dates of surgical privileges: FROM (mm/dd/yy) TO (mm/dd/yy)

Please indicate the age group of the patients for each type of ankle surgery privileges approved by the hospital.

- | | |
|-------------------------------|---------------------------------|
| N Neonates (1 to 30 days) | C Children (1 year to 15 years) |
| I Infants (30 days to 1 year) | A Adult (15 years and older) |

Privilege Granted For	Number of Times Performed in Past 3 Years	Ankle Surgery Procedures
<input type="checkbox"/> N <input type="checkbox"/> I <input type="checkbox"/> C <input type="checkbox"/> A		1. Closed reduction of fracture
<input type="checkbox"/> N <input type="checkbox"/> I <input type="checkbox"/> C <input type="checkbox"/> A		2. Open reduction of fracture
<input type="checkbox"/> N <input type="checkbox"/> I <input type="checkbox"/> C <input type="checkbox"/> A		3. Arthroscopy
<input type="checkbox"/> N <input type="checkbox"/> I <input type="checkbox"/> C <input type="checkbox"/> A		4. Arthrotomy
<input type="checkbox"/> N <input type="checkbox"/> I <input type="checkbox"/> C <input type="checkbox"/> A		5. Excise benign/malignant lesions - soft tissue/osseous
<input type="checkbox"/> N <input type="checkbox"/> I <input type="checkbox"/> C <input type="checkbox"/> A		6. Arthrodesis
<input type="checkbox"/> N <input type="checkbox"/> I <input type="checkbox"/> C <input type="checkbox"/> A		7. Other:

Signature _____

Print Name _____ Date _____

Specialty Department _____

Name of Hospital _____

Mailing Street _____

City _____ State _____ Zip _____

Phone Number _____

E-mail _____

Affix Seal Here