Workers' Compensation Division
Department of Consumer and Business Services

# Physician Associate's Statement of Certification

By my signature below, I certify that I am a physician associate licensed by:

☐ Oregon Medical Board (Board of Medical Examiners). License no.: _____

☐ Other _____ License no.: _____

I have reviewed and understand the *Physician Associate's Handbook* along with the enclosed informational packet. I agree to treat patients with Oregon on-the-job injuries in accordance with Oregon law.

Signature: _____ Date: _____

(Please print)

Name: _____

Primary business address: _____

_____

Phone no.: _____

Fax no.: _____

Business email: _____

FEIN (Federal employer tax identification number) (if available): _____

NPI (National provider identifier) (if available): _____

Please return this form to:

Workers' Compensation Division
Policy Team
350 Winter St. NE
P.O. Box 14480
Salem, OR 97309-0405

Fax: 503-947-7514

Once we receive your certification statement, we will send you a confirmation notice.

440-3650 (6/24/DCBS/WCD/WEB)