



OREGON BOARD OF MEDICAL IMAGING

800 NE Oregon Street – Suite 1160A

Portland, OR 97232-2162

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Website: <http://www.oregon.gov/OBMI/>

Email: OBMI.Info@state.or.us

Updated Information Form

Mail or Fax this form back to the Address or Fax Number Listed Above.
(Please Only Print Your Information Below. This form "MUST" be signed.)

UPDATED RECORDS FOR:

Check all that apply: New Address New Employer New Supervising Physician Social Security No.
 New Name (You Must Attach A Copy of a Legal Document Showing Name Change. (Example: Driver's or Marriage License))

NEW LICENSEE INFORMATION

Last Name:		First Name:		Middle Name:		Maiden/Other:	
Mailing Address			City:		State:		Zip Code
OBMI (Medical Imaging) License No.		Home Phone No:			Cell Phone No:		
Email Address:				Social Security No. (Mandatory):			

NEW EMPLOYER INFORMATION

Employer:							
Employer Address:		City:		State:		Zip Code:	
Post Office Box:		Business Phone No:		Business Fax No:			
Supervisor's Name:			Your Start Date:				

I, (the Licensee) declare that the above information is true to the best of my knowledge.

Licensee Signature: _____

Date _____

Your Supervising Physician Fills Out the information below.

SUPERVISING PHYSICIAN INFORMATION

I certify that _____ will be under my supervision while practicing Medical Imaging at the facility above.

Physicians Printed Name and Title (Example: DC, DPM, MD, DO.) _____

Physicians Signature: _____