

Oregon Department of Consumer and Business Services

Division of Financial Regulation
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Retainer Medical Practice Renewal Application

Applicant information

Name of applicant: _____

Domicile: _____ Date established: _____ FEIN: _____

Assumed business name: _____

Other identities (if applicable): _____

Mailing address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____ Email: _____

Physical address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____ Email: _____

Administrative contact person: _____

Address of administrative contact: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____ Email: _____

Name of registered agent at registered office: _____

Address of registered office: _____

City: _____ State: _____ ZIP: _____

List the physical and mailing addresses, phone numbers, fax numbers, email addresses, and website addresses for each location providing retainer medical services, if different from above:

List the names and Oregon license numbers of all providers delivering services through the retainer medical practice:

During the past year has the retainer medical practice received a license or registration to transact business as a retainer medical practice in another jurisdiction?

Yes No

If yes, identify jurisdiction and agency:

During the past year, has the retainer medical practice's license or registration in another jurisdiction been suspended, revoked, or not renewed?

Yes No

If yes, provide contact information for the agency taking action, action taken, date of action, and the reason for the action:

During the past year, has the applicant filed for bankruptcy?

Yes No

If yes, provide details:

Also provide reasons why the bankruptcy should not be used by the director as evidence that the applicant is not financially responsible and form the basis for a denial of recertification:

Has the applicant, a person with control of the applicant, or a provider who provides services on behalf of the applicant been charged with a felony or with a misdemeanor involving dishonesty?

Yes No

If yes, explain:

Total number of people under a retainer medical agreement in prior calendar year: _____

Total number of people under a retainer medical agreement that voluntarily terminated the retainer medical practice agreement during the prior calendar year: _____

Total number of people under a retainer medical agreement whom the retainer medical practice terminated the agreement: _____
(For each patient, explain on a separate sheet why the agreements terminated.)

Total number of applicants declined by the retainer medical practice: _____
(For each applicant, explain on a separate sheet the reason for denial.)

Applicant attestations:

1. Providers delivering services under the retainer medical agreement are licensed or certified under ORS chapters 677, 678, 684, or 685 and the services provided will be limited to primary care services allowed
2. The applicant is not and has never been authorized in this or any other state to transact insurance or act as an insurer, managed care organization, health care services contractor, or similar entity. [OAR 836-200-0305(1)(c)(A)(ii)]
3. The applicant is not controlled by any person authorized in this or any other state to transact insurance or act as an insurer, managed care organization, health care services contractor, or similar entity. [OAR 836-200-0305(1)(c)(A)(iii)]
4. The applicant continues to structure the retainer medical practice to ensure that all services promised under the retainer medical agreement are within the capacity of the practice to provide in a timely manner. [OAR 836-200-0305(1)(c)(A)(iv)]
5. The applicant continues to be financially responsible. [OAR 836-200-0305(1)(c)(A)(v)]
6. Marketing materials, websites and retainer medical agreements contain, on the first content page, the required disclosures. [OAR 836-200-0315]
7. The applicant does not discriminate based on race, religion, gender, sexual identity, sexual preference, or health status. [OAR 836-200-0305(1)(c)(A)(viii)]
8. The applicant is authorized to conduct business in the state of Oregon and has complied with all registration requirements of this state. [OAR 836-200-0305(1)(c)(A)(ix)]
9. The information provided in the renewal application and all supplemental and additional information is true and complete, and the applicant will submit to the jurisdiction of the courts of the State of Oregon. [OAR 836-200-0305(1)(c)(A)(x)]

I, _____, make the foregoing attestations on behalf of the applicant
retainer medical practice. I am authorized to make such attestations by virtue that I hold the
_____ position of with respect to the applicant.

Signature: _____ Date: _____

We _____
(Name) (Position title)

And _____
(Name) (Position title)

certify that we are officers with responsibility for the operation of the organization named in the
foregoing application, that we know the contents thereof, and each of the statements and answers
made is true and complete to the best of our knowledge and belief. Further, the organization
submits to the jurisdiction of any court of competent jurisdiction in Oregon for the adjudication
of any issues arising out of its retainer medical practice, agrees to comply with all requirements
necessary to give such court jurisdiction, and will abide by the final decision of such court or any
appellate court in the event of an appeal.

Officer 1 signature: _____ Date: _____

Officer 2 signature: _____ Date: _____