IOWA BOARD OF MEDICINE
400 S.W. 8th Street, Suite C, Des Moines, IA 50309-4686
(515) 281-6641 www.medicalboard.iowa.gov

VERIFICATION OF MEDICAL CONDITION

Applicant: You are required to provide a statement explaining any medical condition you have experienced that has had an ongoing or adverse impact on your ability to function and practice. Physicians who had a condition that interrupted their education or training should also complete this form.

The physician who diagnosed and provides, or provided, treatment for the condition should complete this form.

Treating Physician: Complete and mail this form directly to the Iowa Board of Medicine. This form is also on our website as a PDF document which can be completed using the computer and printing the document. The applicant's signature on this form authorizes the release of information, favorable or otherwise, directly to the Board.

Applicant's Name (Print Legibly): _____

Applicant's Date of Birth (Month/Day/Year): _____

Nature of Medical Condition (Include specific diagnosis):

_____

_____

_____

Summary of Treatment:

_____

_____

_____

Treatment Period: From: _____ To: _____

Recommended Treatment:

_____

_____

_____

Is/Was the applicant in compliance with his/her treatment? Yes ☐ No ☐

If no, please explain.

_____

_____

_____

Is the applicant taking any prescribed medications for this condition? Yes ☐ No ☐
If yes, list the medication(s).

_____

_____

_____

Provide a summary of other prescription medications this applicant is taking.

_____

_____

_____

Has this medical condition in any way affected the applicant's ability to practice medicine with reasonable skill and safety? Yes ☐ No ☐
If yes, please explain.

_____

_____

_____

Do any limitations need to be in place with regard to the applicant's practice of medicine? Yes ☐ No ☐ If yes, please explain.

_____

_____

_____

If treatment were to cease for any reason, could the applicant's condition in any way affect his/her ability to practice medicine with reasonable skill and safety? Yes ☐ No ☐
If yes, please explain.

_____

_____

_____

Is ongoing monitoring warranted? Yes ☐ No ☐
If yes, please explain.

_____

_____

_____

Treating Physician Information

Physician's Name (print legibly):_____

Signature:_____ **Date:**_____

Address:_____

Phone:_____ **Fax:**_____

Authorization for Release of Information – Verification of Medical Condition

The applicant must sign this form and submit it with the Verification of Medical Condition form. The treating physician may retain this release of information for their records.

I, _____ (print name), do hereby authorize a disclosure of records concerning myself to the Iowa Board of Medicine (IBM). This release includes records of a public, private or confidential nature.

I acknowledge that the information released to the IBM may include material that is protected by federal and/or state laws applicable to substance abuse and mental health information. If applicable, I specifically authorize the release of confidential information to and from the IBM relating to substance abuse or dependence and/or mental health.

I further agree that the IBM may receive confidential information and records, including, but not limited to the following records:

- Medical Records
- Education Records
- Personnel or employment records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Postgraduate training (internship, residency & fellowship) records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Any information the IBM deems reasonable necessary for the purposes set forth in this release.

Release of Liability. I do hereby irrevocably and unconditionally release, covenant not to sue, and forever discharge any person or entity, including but not limited to any medical school, residency or fellowship training program, hospital, health care provider, health care facility, licensing board, impaired practitioner program, agency, or organization, which releases information to the IBM pursuant to this release from any liability, claim, or cause of action arising out of the release of such information. I further irrevocably and unconditionally release, covenant not to sue, and forever discharge the IBM, the State of Iowa, and its employees and agents from any liability, claim, or cause of action arising out of the collection or release of information pursuant to this release.

A photocopy of this release form will be valid as an original thereof, even though the photocopy does not contain an original writing of my signature.

This authorization is valid until completion of the licensing process. I understand I have the right to revoke this authorization in writing, except to the extent that the IBM has already taken action in reliance upon this consent.

I have read and fully understand the contents of this "Authorization to Release Information".

_____ _____

Signature of Physician Date

PROHIBITION ON REDISCLOSURE

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa Code Ch. 228) prohibit further disclosure without the specific written consent of the patient except as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.