Dear Practitioner,

As of April 1, 2017, the Medical Staffs associated with Legacy Health have implemented new system-wide medical staff policy for late career practitioners who are age 70 and above that request or have clinical privileges within our facilities.

The adoption of this policy is many years in the making. Legacy Emanuel Medical Staff had initially adopted a policy back in 2011. Since that time, a system-wide task force has been meeting to define a policy and associated processes to ensure our late career practitioners can be reasonably assessed in a manner that ensures both patient safety and physician wellness. The Medical Staff taskforce has therefore come up with a three-part assessment that will be required as part of the application for initial appointment or reappointment for all practitioners on or after the age of 70, who request clinical privileges to assess clinical competency. Additional assessments will be required every two years.

Below is an outline of the new policy’s requirements:

- An assessment by an Occupational Medicine Specialist (or practitioner with similar qualifications such as primary care physician) to assess physical capacity.
- A mental capacity evaluation by a Neuropsychologist (or practitioner with similar qualifications). This exam includes completion of the MicroCog online testing tool with a follow-up assessment by a Neuropsychologist.
- An expanded peer review assessment

The medical staff will cover the cost of the MicroCog Assessment and evaluation and believes a physical assessment, should be covered under by your health insurance. We understand this is a significant change and therefore are sending this letter to you six months in advance of your reappointment in an effort to provide you adequate time to complete these requirements. Attached is the policy and required documents necessary to complete these requirements.

We thank you in advance for your cooperation in adhering to this new policy. Should you have questions, you are welcome to me at (503) 525-7656 for assistance or connect directly with any of your medical staff leaders.

Sincerely,

Megan Veliquette, CPCS
Manager, Medical Staff Services
Legacy Health

Enclosures
SECTION:  Late Career Practitioners

Policy:
It is the policy of the Medical Staff that the Credentials Committee specifically considers, on an ongoing basis, the abilities, competencies, and health status (ability to perform) of each practitioner who has clinical privileges in accordance with the Medical Staff bylaws and policies and procedures related to clinical privileging. This policy was implemented for all practitioners age 70 and older and can be utilized for practitioners under the age of 70 for reasonable cause.

Procedure:
1. Upon application for initial appointment or reappointment on or after the age of 70, or upon the request of the Credentials Committee for reasonable cause regardless of age, each practitioner requesting clinical privileges shall, as a required element of his/her application, undergo the following examinations. A list of approved practitioners is provided (see Appendix D for list and instructions.) These examinations are required every 2 years after initial evaluation after age 70.
   a. By an Occupational Medicine Specialist (or practitioner with similar qualifications such as primary care physician) to assess their physical capacity. Cost of this exam should be covered by the practitioner's health insurance.
   b. By a Neuropsychologist (or practitioner with similar qualifications) to assess their mental capacity for the privileges requested. This exam includes completion of the MicroCog online testing tool with a follow-up assessment by a Neuropsychologist. The Hospital's Medical Staff will cover the cost of this test and evaluation. However, if additional assessments are recommended, these will be at the practitioner's own expense.

2. The outcome must be documented on the approved form (see Appendix B) and submitted by the date requested by the Credentials Committee.

3. The examinations are a “fitness-to-work” evaluation, which consists of two parts: cognitive and physical assessment. The examination must indicate that the practitioner has no physical or mental problems that may interfere with the safe and effective provision of care permitted under the privileges granted. Findings that have the potential to interfere with the safe and effective provision of care under the privileges requested will be assessed by the Credentials Committee and will be processed in accordance with the Medical Staff bylaws, including adherence to state or federally mandated reporting requirements.

4. During the initial appointment or reappointment process, the MSS will send out the “Expanded Peer Reference Form” every 2 years concurrent with the same year the physical and neuropsychiatric evaluations are due.

5. In addition, a practitioner may be required to undergo a focused review of his/her clinical performance as part of the assessment of his/her capacity to perform requested privileges. Such focused review may be required in the absence of any previous performance concerns. The scope and duration of the focused review shall be determined by the Credentials Committee.

6. After receipt of the completed examination, if the Credentials Committee determines further action needs to be taken concerning the practitioner’s Medical Staff membership and clinical privileges (in accordance with Medical Staff Bylaws), a recommendation will be forwarded to the Medical Executive Committee (MEC) and Board for approval.

Responsibility of the Medical Staff Services Department:
1. Upon application for initial appointment or reappointment on or after reaching the age of 70, or for reasonable cause, the Medical Staff Services Department (MSS) will notify affected practitioners of the requirement for the physical and mental examination in accordance with the aforementioned policy.

2. The notification from the MSS will include:
   A. A copy of this policy.
   B. A copy of the approved form upon which the examination must be documented (Appendix B).
   C. The date that the results of the examination are due to MSS.
   D. A copy of the current clinical privileges held or requested by the practitioner.
3. MSS will send out the “Expanded Peer Reference Form” every 2 years concurrent with the same year the physical and neuropsychiatric evaluations are due.

4. Upon receipt of the examination results, the Medical Staff President or Credentials Committee Chair (or designees) will review the information.
   a. It is the expectation of the Legacy Health Board of Directors, that the Medical Executive Committees and Credentials Committees will consider all elements of a practitioner’s results when determining the capacity of the individual to perform the requested privileges. Each element of the review (physical examination, microcog assessment, expanded peer review, focused review (if performed), and any other relevant information on the practitioner) will be considered in aggregate to create an informed view of the capacity of the individual to perform the required privileges.
   b. If findings do not identify a potential issue with the safe and effective provision of care under the privileges requested, the results will be filed in the practitioner’s confidential file in the MSS Office.
   c. However, if in the opinion of the Medical Staff President or Credentials Committee Chair (or designees), there is a potential issue with the safe and effective provision of care under the privileges requested, the examination results will be shared with the Credentials Committee for recommendation.

5. If a required examination is not obtained within 90 days of notification, the practitioner will be considered to have voluntarily relinquished his or her clinical privileges and any application for reappraisal/reappointment will not be processed further.

Appendices:
1. A: Elements of a Screening Evaluation(s)
2. B: Screening Physical Evaluation Report Form(s)
3. C: Health Professional Intake Form
4. D: Instruction Sheet for Practitioner
5. E: List of suggested practitioners

References: Review of the following sources indicate some type of increased evaluation for late career practitioners.
22. Stanford Hospital/Lucile Packard Children’s Hospital. August 2012: Late Career Practitioner Policy.
23. Stanford Hospital/Lucile Packard Children’s Hospital. 8/3/12: Late Career Practitioner Policy FAQs.
27. Protonmag-Massachusetts General Hospital. Spring 15: Out of Practice
31. Providence Health & Services. January 2015: Late Career Health Assessment – Note to the Examining Physician
32. Providence Health & Services. June 24, 2015: Late Career Practitioner Assessment
33. Providence Health & Services. August 5, 2015: Late Career Practitioner Assessment
34. Providence Health & Services. January 2015: Clinical Core Competencies Evaluation Form
35. PeaceHealth Southwest Medical Center. January 8, 2016: Procedure for Reappointment

Originator/Owner: Medical Staff Services
Approval: LEMC Credentials Committee 8/4/11, Medical Executive Committee 8/22/11 and 9/26/11. Legacy Health MQ&C 10/20/11
System-Wide Approval 8/16/16
NOTE TO THE EXAMINING PHYSICIAN:
The following elements of a medical evaluation, including history, physical examination and laboratory assessment, should be modified as appropriate to address the age, clinical condition, and privileges requested by the practitioner. Therefore please be sure to review the practitioner’s requested privileges before conducting this evaluation.

In order to respect the confidentiality of the practitioner’s medical information, the medical staff does not expect you as the examining physician to submit the complete results of your medical evaluation. The medical staff is only interested in, and should only receive a report on, those aspects of the practitioner’s health that have the potential to adversely affect their ability to carry out the requested privileges. Please use the form attached to this document in submitting the results of your assessment to the medical staff rather than submitting a complete history and physical examination.

**Physical Fitness to Work Evaluation**
- Complete form
- Comprehensive physical exam to include hearing and vision (if indicated)
- Full set of vital signs

**Neuropsychiatric Evaluation**
- History
  - Mental Status and Activities
    - Gross cognitive functioning
    - Attention and concentration
    - Memory functioning
    - Language functions
    - Reasoning/judgment
    - Emotional functioning
- Procedures
- Test Results
- Impression and Discussion
Legacy Health
Screening Physical Evaluation Report Form – Appendix B

Practitioner: _______________________________ Date of Examination: __________________

In the history are there symptoms or conditions that raise concern about this clinician’s ability to consistently perform the requested privileges in a safe and effective manner?
No: ______ Yes: ______ If yes, please elaborate below

In the examination are there findings that raise concern about this clinician’s ability to consistently perform the requested privileges in a safe and effective manner?
General: No: ______ Yes: ______ If yes, please elaborate below
Sensory: No: ______ Yes: ______ If yes, please elaborate below
Neurological: No: ______ Yes: ______ If yes, please elaborate below

Tests and studies performed on this clinician raise concern about this clinician’s ability to consistently perform the requested privileges in a safe and effective manner:
No: ______ Yes: ______ If yes, please elaborate below

Do you have any recommendations for further study or evaluation?
No: ______ Yes: ______ If yes, please elaborate below

I attest that I have performed a complete history and physical examination including a neurological and cognitive/mental status assessment on this practitioner, and that I have reviewed the clinical privileges requested by this practitioner.

It is my professional opinion that this practitioner:

__________ Is capable of safely performing all privileges requested
__________ Is capable of safely performing all privileges requested except those detailed below
__________ Is not capable of safely performing the clinical privileges requested
__________ Requires further evaluation regarding issues or concerns below
__________ Requires proctoring for further evaluation

Details/Concerns (attach a separate document if more space is needed) – In addition, please attach your full dictated report.

By signing below, I attest this exam has been completed according to Appendix A – “Elements of Screening Physical Assessment of Practitioners” and that I have reviewed Appendix C – “Health Professionals Intake Form”.
Signature: _______________________________ Date: __________________
Print Name: _______________________________

Return form to: Legacy Medical Staff Services, 1650 NW Naito Pkwy Suite # 185 Portland, OR 97209, fax 503-525-7650
Legacy Health

Screening Neuropsychiatric Evaluation Report Form – Appendix B

Practitioner: _______________________________ Date of Examination: ________________

In the history are there symptoms or conditions that raise concern about this clinician’s ability to consistently perform the requested privileges in a safe and effective manner?
No: ______ Yes: ______ If yes, please elaborate below

In the examination are there findings that raise concern about this clinician’s ability to consistently perform the requested privileges in a safe and effective manner?
No: ______ Yes: ______ If yes, please elaborate below

Tests and studies performed on this clinician raise concern about this clinician’s ability to consistently perform the requested privileges in a safe and effective manner:
No: ______ Yes: ______ If yes, please elaborate below

Do you have any recommendations for further study or evaluation?
No: ______ Yes: ______ If yes, please elaborate below

I attest that I have performed a complete history including a neurological and cognitive/mental status assessment on this practitioner, and that I have reviewed the clinical privileges requested by this practitioner.

It is my professional opinion that this practitioner:

__________ Is capable of safely performing all privileges requested

__________ Is capable of safely performing all privileges requested except those detailed below

__________ Is not capable of safely performing the clinical privileges requested

__________ Requires further evaluation regarding issues or concerns below

__________ Requires proctoring for further evaluation

Details/Concerns (attach a separate document if more space is needed) – In addition, please attach your full dictated report.

By signing below, I attest this exam has been completed according to Appendix A – “Elements of Screening Physical Assessment of Practitioners” and that I have reviewed Appendix C – “Health Professionals Intake Form”.
Signature: ________________________________ Date: ______________________________
Print Name: ______________________________

Return form to: Legacy Medical Staff Services, 1650 NW Naito Pkwy Suite # 185 Portland, OR 97209, fax 503-525-7650
Personal Information:

1. Today’s date: ____________________
2. Name (please print clearly): ___________________________________________________________
3. DOB (mm/dd/yy): ____________________
4. ID#: ____________________________
5. State License #: __________________ DEA#: ________________________
6. Sex (circle one): Male Female
7. Cultural Background (circle one):
   - White
   - Native American
   - Chinese
   - Arab
   - Black
   - South Asian
   - Japanese
   - Eastern European
   - Hispanic
   - Persian
   - Korean
   - Vietnamese
   - Pacific Islander
   - Other:___________________________________________________________
8. First Language (circle one):
   - English
   - Mandarin
   - Italian
   - Korean
   - Spanish
   - Cantonese
   - German
   - Tagalog
   - French
   - Vietnamese
   - Portuguese
   - Farsi
   - Japanese
   - Other: __________________________________________________________
9. Second Language (circle one):
   - English
   - Mandarin
   - Italian
   - Korean
   - Spanish
   - Cantonese
   - German
   - Tagalog
   - French
   - Vietnamese
   - Portuguese
   - Farsi
   - Japanese
   - Other: __________________________________________________________
10. Where did you first learn English? (circle one)
    - Home
    - Graduate/Medical School
    - Primary School
    - Work
    - High School
    - Television/Movies/Media
    - College
    - Other: _________________________________
11. At what age did you first start to learn English? _________________________________
12. What language do you primarily use at work? _________________________________
13. What language do you primarily use at home? _________________________________
14. Please provide an estimate of the breakdown of your patient population by ethnic background:
    - White _____%  Asian/Pacific Islander _____%  Native American _____%  
    - Hispanic _____%  Black _____%  Middle Eastern _____%  
    - Other ethnicity _____%  
    - a. What percentage of the time do you use a translator? ______%
15. Please estimate patient population by sex: Male: ____% Female: ____%
16. Please estimate patient population by age:
   0-17 yrs old _____%  18-30 yrs old _____%
   31-54 yrs old _____%  55-74 yrs old _____%  75 yrs or older _____%
17. Current marital status (circle one):
   Married/domestic partnership  Single  Separated  Divorced
18. How many times have you been married: _________________________________________________
19. Year(s) in which you were married or lived in a committed relationship (e.g. 1974-1977, 1989, 1990-1995):
   ________________________________________________________________________________

School and Residency Information:
20. Have you ever been diagnosed with a learning disability? (circle one) Yes  No
21. If yes, did you ever receive school accommodations to help with your disability? (circle one) Yes  No
22. Have you ever been prescribed medicine to help with your disability? (circle one) Yes  No
23. If yes, what medication were you prescribed? (circle all that apply)
   Methylphenidate (Ritalin)  Pemoline (Cylert)  Dextroamphetamine-amphetamine (Adderall)
   Tricyclics  Other: _____________________________________________________
24. What year did you take the NBME certifying exam or UMSLE? (or ECFMG for foreign medical graduates)?
   ________________________________________________________________________________
   If you did not complete a residency program, check here. _____
25. From which college did you graduate (if international, please also list city and country)?
   ________________________________________________________________________________
26. From which medical training program did you graduate (if international, please also list city and country)?
   ________________________________________________________________________________
27. What is your degree? (circle all that applies) MD  DO  DPM  DMD  DDS  PA  NP  CNM
28. What year did you graduate? ________________________
29. Did you receive any additional graduate education? (circle one) Yes  No
30. If yes, in what field did you receive your degree? (circle all that apply)
   MPH  Masters  PhD  Other: ___________________________________________________
31. Did you experience any behavioral or disciplinary problems in your medical training program? If yes, please explain.
   ________________________________________________________________________________
32. Did you experience any academic problems in your medical training program? If yes, please explain.
   ________________________________________________________________________________
   ________________________________________________________________________________
33. If you did a residency, how many years of residency training did you complete? __________________
34. Where did you complete your residency training (if international, please list, city and country)?
   ________________________________________________________________________________
35. In what specialty did you receive your residency training? (circle all that apply)
   Family Practice  Dermatology  Pathology
   Internal Medicine  Radiology  Anesthesiology
   Pediatrics  Neurology  Colon/Rectal Surgery
   Psychiatry  Allergy/Immunology  Obstetrics/Gynecology
   Surgery  Emergency Medicine  Preventive Medicine
   Ophthalmology  Orthopedic Surgery  Medical Genetics
36. Did you ever leave or were you asked to leave a medical training program or residency program for any reason? (circle one) Yes No

37. If yes, please explain. ________________________________________________________________
__________________________________________________________________________________

38. Are you currently certified by the American Board of Medical Specialties (ABMS) in any specialties? (circle one) Yes No (if No, skip to 45)

39. If so, which specialty and/or specialties are you board certified (select all that apply)?

- Family Practice
- Internal Medicine
- Pediatrics
- Psychiatry
- Surgery
- Ophthalmology
- Neurological Surgery
- Physical Medicine & Rehab
- Plastic Surgery

- Dermatology
- Radiology
- Neurology
- Allergy/Immunology
- Emergency Medicine
- Orthopedic Surgery
- Nuclear Medicine
- Thoracic Surgery

- Pathology
- Anesthesiology
- Colon/Rectal Surgery
- Obstetrics/Gynecology
- Preventive Medicine
- Medical Genetics
- Otolaryngology
- Urology

- Other: _______________________________

40. Primary certification: _________________________________________________________________

41. On what date did you originally receive your board certification? ___________________________

42. On what date did you receive your most recent board certification? _________________________

43. Has your certification ever expired? Yes No

44. Secondary certification: _______________________________________________________________

45. Are you currently eligible to receive certification from the ABMS in any specialty? (circle one) Yes No

46. If yes, which specialty/specialties are you board eligible (select all that apply)?

- Family Practice
- Internal Medicine
- Pediatrics
- Psychiatry
- Surgery
- Ophthalmology
- Neurological Surgery
- Physical Medicine & Rehab
- Plastic Surgery

- Dermatology
- Radiology
- Neurology
- Allergy/Immunology
- Emergency Medicine
- Orthopedic Surgery
- Nuclear Medicine
- Thoracic Surgery

- Pathology
- Anesthesiology
- Colon/Rectal Surgery
- Obstetrics/Gynecology
- Preventive Medicine
- Medical Genetics
- Otolaryngology
- Urology

- Other: _______________________________

a. Are you currently certified or eligible for any other medical board? (circle one) Yes No

b. If yes, what specialty? _______________________________________________________________

On what date did you originally receive that board certification? _____________________________

On what date did you receive your most recent board certification? ___________________________

Has your certification ever expired? Yes No
47. What is the nature of your clinical practice? (circle one)  
Solo    Academic    Military  
Group private practice  Group hospital or university  Other: _____________________________

48. What is the setting of your clinical practice? (circle one)  Urban    Rural

49. What is the number of staff employed at your practice? ___________________________________

50. What are their titles? _________________________________________________________________

51. Please indicate how many employees of the following titles you have employed:  
_____ RN/NP       _____ PA        _____ Lab Technicians       _____ Admin Assists  
_____ Medical Assistants       _____ Dental Hygienists       _____ Others

52. Do you currently have malpractice insurance?  (circle one)  Yes    No  
Norcal    MIEC    SCPIE  
The Doctor’s Company       Other: _____________________________________________________

53. If yes, who is your insurance carrier?  (circle one)  

54. With which of the following do you currently share patients? (e.g. make joint management decisions) (check all that apply)  
Nurse practitioners  Physician Assistants  Nurse Midwives  Physicians  Dentists

55. What are your office hours? ___________________________________________________________

56. How many patients do you see in your office per day? _____________; per week? _______________

57. For your most recent week of typical practice, how many hours did you spend:  
a. Seeing patients in an office or clinic?     ________________ hrs/week  
b. Seeing patients in hospital/not emergency room?   ________________ hrs/week  
c. Seeing patients in an emergency or urgent care facility?  ________________ hrs/week  
d. Seeing patients in nursing homes, other extended care facility? ________________ hrs/week  
e. Seeing patients in home visits?     ________________ hrs/week  
f. Performing surgery?       ________________ hrs/week  
g. Administration?  
h. Teaching?  
i. Other: ____________________________________  ________________ hrs/week

58. On average, how many times a month are you on call?   _____________________________

59. With whom do you take call?   University    Hospital  
Other: _____________________________  Kaiser  Outpatient Clinic

60. If you are a surgeon (including dermatologists, gynecologists, etc.), how many surgeries do you perform, on average, each week?  _______________________________________

61. On average, how many times per month do you seek consultation from other physicians regarding patient care and/or other practice-related matters?  _______________________________________

62. On average, how many times per month do you attend Grand Rounds or other medical conferences at your community hospital or elsewhere in your community?  _______________________________________

63. How many minutes per day, on average, do you spend documenting medical records? _____________

64. How many hours per week do you work (including non-clinical work, record keeping, etc)? ___________

65. How many days of vacation do you take per year? _____________________________

66. What do you do for recreation/relaxation?  ______________________________________________

67. On average, how many hours do you sleep per night?  ______________________________________

68. Does work regularly interfere with your personal life?     Yes    No
69. If yes, please indicate with what your work interferes: (circle all that apply)

Weekends   Vacations   Holidays   Children’s activities
Other: ____________________________________________________________________________

Disciplinary questions and other related info

70. On average, how many alcoholic beverages do you consume per week? ________________

71. What is your preferred alcoholic beverage? (circle all that apply)

Beer   Wine   Liquor   Other: ________________

72. Has anybody ever complained about the amount of alcohol you drink or your behavior while drinking alcohol? (If no, skip to question #75)  Yes   No

73. If yes, who? (circle all that applies)

Spouse/partner   Family member   Co-worker   Boss
Other: ____________________________________________________________________________

74. What year(s)? ________________

75. Have you ever had any problems related to your alcohol use? (If no, skip to question #78) (circle one)  Yes   No

76. If yes, what year(s)? ________________

77. What was the problem? ________________

78. Have you ever been in a treatment program for substance abuse problem? (If no, skip to question #80)  Yes   No

79. If yes, please give dates and describe the program (e.g. self referred AA, etc.):
__________________________________________________________________________________
__________________________________________________________________________________

80. Have you ever been referred to a Diversion Program? (If no, skip to question #84)  Yes   No

81. If yes, what year(s)? ________________

82. Have you ever been referred to a hospital’s Well Being Committee or Peer Review Committee? (If no, skip to question #84)  Yes   No

83. If yes, please explain. __________________________________________________________________
__________________________________________________________________________________

84. On average, how many caffeinated beverages do you consume per day? ________________

85. Have you ever lost or settled a malpractice case? (If no, skip to question #87)  Yes   No

86. If yes, how many and what was the amount awarded to each case? ________________
__________________________________________________________________________________
__________________________________________________________________________________

87. Have you ever been convicted of a crime? (If no, skip to end)  Yes   No

88. If yes, please describe the nature of the crime and specify whether it was a felony or misdemeanor.

89. Please list any medical history (current or significant past)
__________________________________________________________________________________
__________________________________________________________________________________

90. Do you take any prescription medication?  If yes, please list names. ________________
__________________________________________________________________________________

91. Have you had any surgery?  If yes, please list surgery type and dates. ________________
__________________________________________________________________________________
__________________________________________________________________________________
92. Have you been hospitalized at any time? If yes, please give reasons and dates. _________________
__________________________________________________________________________________

93. Do you have any psychiatric history, including any problems requiring hospitalization, therapy or medication?
__________________________________________________________________________________

94. Have you had any significant injuries? If yes, please give details. ______________________________

95. Do you have any family history of Parkinson’s disease, dementia (of any type), depression or anxiety?
   If yes, please give details __________________________________________________________________________
__________________________________________________________________________________

The above information is true and accurate to the best of my knowledge.

_____________________________________________________ _____________________________
Signature        Date

_____________________________________________________ _____________________________
Occupational Medicine practitioner signature                                        Date

_____________________________________________________ _____________________________
Neuropsychology practitioner signature     Date

Legacy Health Professional Intake Form – Return form to both Physical and Neuropsychiatric providers - Page 6
Legacy Health

Instruction Sheet for Practitioner – Appendix D

1) Make an appointment for a physical examination with an approved Occupation Medicine or Primary Care provider at least 2-3 months prior to your reappointment date.

2) Make an appointment with an approved Neuropsychologist at least 2-3 months prior to your reappointment.

3) Fill out the Legacy Health Professional Intake Form and return it to the 2 practitioners noted above at least 2 weeks prior to your scheduled examinations.

4) Anticipate 1 hour of time for completion of your physical assessment with the Occupational Medicine or Primary Care provider. Provide a copy of the “Elements of Screening Physical Assessment of Practitioner – Appendix A” and the “Screening Physical Evaluation Report Form - Appendix B” to this provider. He/she will need to return Appendix B to Legacy Health Medical Staff Services, 1650 NW Naito Parkway Suite #185, Portland, OR 97209.

5) Anticipate 1-3 hours of time for completion of your psychological assessment. This will consist of a computerized assessment tool. A second visit or other tests may be required and will be selected as necessary. Provide a copy of “Elements of Screening Physical Assessment of Practitioner – Appendix A” and the “Screening Neuropsychiatric Evaluation Report Form - Appendix B” to your Neuropsychiatric provider. He/she will need to return Appendix B to Legacy Health Medical Staff Services, 1650 NW Naito Parkway Suite #185, Portland, OR 97209.
Legacy Health

List of Suggested* Practitioners for Physical Assessment – Appendix E

**Physical Fitness to Work Evaluation**

Concentra, Inc.
3449 N Anchor St, Ste 300A
Portland, OR  97217
(503) 283-0013

12518 NE Airport Way, Ste 110
Portland, OR  97230
(503) 256-2992

2225 NW Towncenter Dr
Beaverton, OR  97006
(503) 726-1021

6405 SW Rosewood, Ste B
Lake Oswego, OR  97035
(503) 675-7603

**Neuropsychiatric Evaluation**

Transitions Professional Center, LLC
3735 SW River Parkway
Portland OR 97239
503-972-7090
fax 503-972-7093
psychologists@transitionspc.com

* Anyone of equal qualifications would be accepted.