



**Oregon State Board of Nursing**

17938 SW Upper Boones Ferry Road • Portland, OR 97224-7012

Phone: 971-673-0685 • Fax: 971-673-0684 • Website/Verification: www.oregon.gov/OSBN

# Registration for Limitation of Liability for Practice without Compensation

Please type or print clearly.

**Name:**

\_\_\_\_\_  
*Last First Middle Former/Maiden*

**Mailing**

**Address:**

\_\_\_\_\_  
*Street No. City & State Zip Code*

**Contact**

**Numbers:**

\_\_\_\_\_  
*Home Work E-mail (optional)*

**Identification**

**Information:**

\_\_\_\_\_  
*Social Security Number Current Oregon License Number*

I hereby register with the Oregon State Board of Nursing for Limitation of Liability pursuant to ORS [676.340](#) and ORS [676.345](#) for health care services I provide without compensation. In registering for the Limitation of Liability I attest to the following:

- Before providing health care services I will obtain a signed statement from the patient, or the person authorized by law to make health care decisions for the patient, that notifies them that the health care services provided by me are without compensation and that I may be held liable for injury, death or other loss arising out of providing these service only for my acts of gross negligence.
- I will provide health care services without compensation except for reimbursement for laboratory fees, testing services and other out-of-pocket expenses.
- I will only provide health care services without compensation that are within the scope of my license to practice nursing.
- I understand that this registration is only valid for one year and must be renewed annually. Additionally, I understand that there is no fee for this registration and, since the registration is provided at no cost, I will not receive notice to renew my registration. It is therefore my responsibility to renew this registration at the appropriate time.

\_\_\_\_\_  
**Signature of Licensee**

\_\_\_\_\_  
**Date**

**REGISTRATION DATE**

[Blank box for registration date]