

**Oklahoma State Board of Medical Licensure and Supervision
Board Secretary Approval Request**

Date: _____

License Type _____ Number _____ Name _____

Requested Change:

Employment Information

Type of change: New Employment ___ Change of Employment ___ Additional Employment ___

Practice Address: _____

Employment Contact Name: _____

Practice Phone: _____ Hours Requested _____

Fill out Employment Statement of Work Page

Continuing Education

Course Title	Date	Hours	Remarks

Community Service

Name of Organization/ Description of Service hours	Date	Hours	Remarks

Therapy

Name of Organization/Description	Date	Hours	Remarks

Other

Name of Organization/Description	Date	Hours	Remarks

Board Secretary Approves _____ Disapproves _____

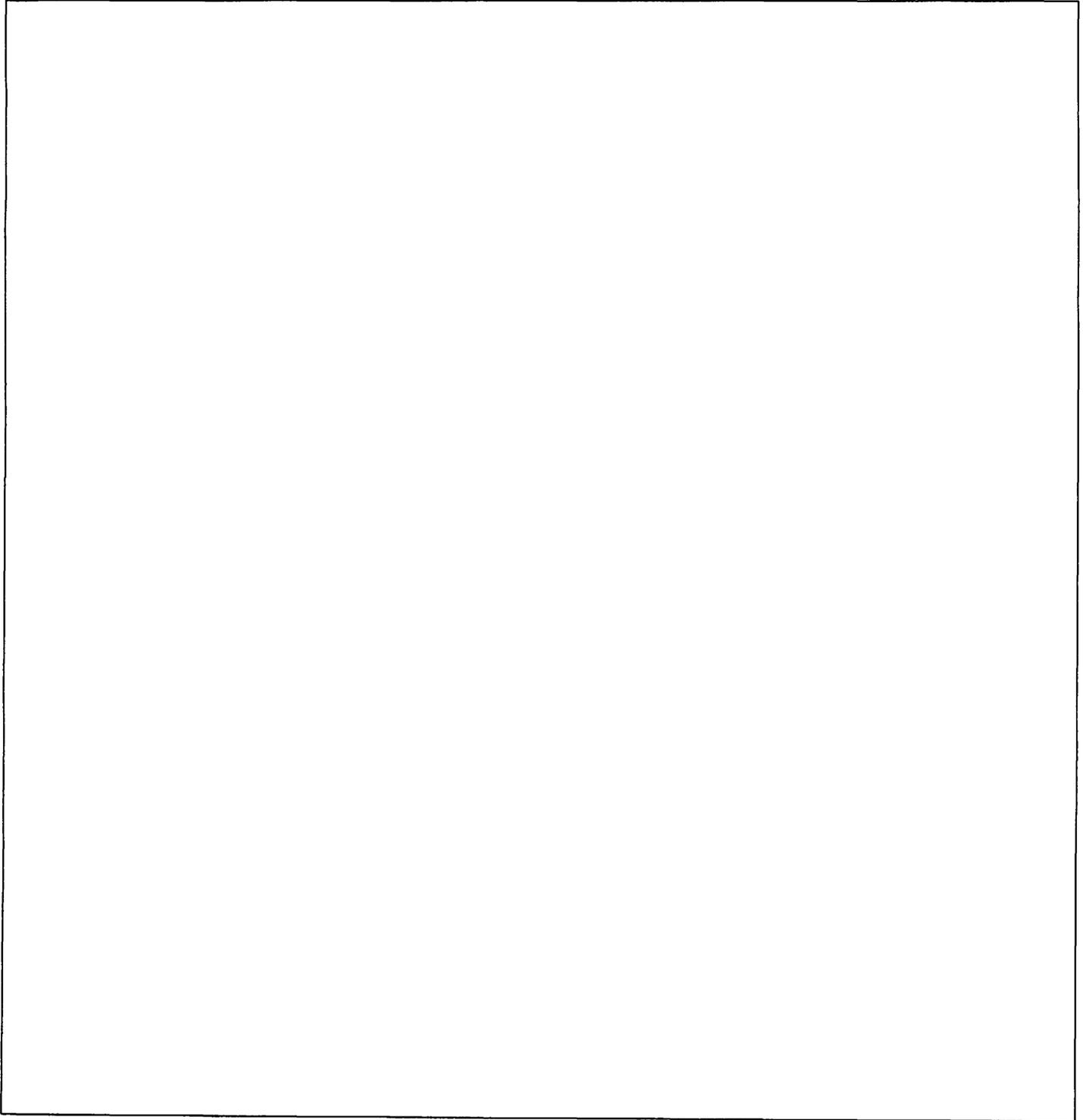
Board Secretary Comments: _____

Board Secretary's Signature _____ Date _____

Applicant/ Licensee's Signature _____ Date _____

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Employment Statement of Work**

Job Duties

A large, empty rectangular box with a thin black border, occupying the majority of the page. It is intended for the user to list the specific job duties for the position.