FORM #1 (Allied)

OKLAHOMA STATE BOARD OF
MEDICAL LICENSURE AND SUPERVISION
PO BOX 18256, OKLAHOMA CITY, OK 73154
(405) 848-6841

VERIFICATION OF EDUCATION

AN EDUCATOR OF THE INSTITUTION FROM WHICH YOU OBTAINED YOUR PROFESSIONAL ACADEMIC DEGREE/CERTIFICATE MUST COMPLETE THIS FORM. THE SEAL OF THE INSTITUTION MUST BE IMPRESSED ON THIS FORM, OR THE STATEMENT AT THE BOTTOM OF THIS FORM MUST BE SIGNED BY THE AUTHOR OF THIS FORM AND THE SIGNATURE NOTORIZED. ALL SIGNATURES MUST BE ORIGINAL.

I, _____, DO HEREBY CERTIFY THAT THE APPLICANT,
Name of educator

_____ ATTENDED _____
Name of applicant Name of institution

LOCATED IN _____, _____, FROM _____ / _____ / _____ TO _____ / _____ / _____
City State mo. day year mo. day year

AND WAS AWARDED THE DEGREE/CERTIFICATE OF _____.

A TRUE COPY OF THE DIPLOMA/CERTIFICATE AWARDED IS _____ IS NOT _____ ATTACHED (If not attached, explain briefly why not)

_____.

RECORDS OF THIS INSTITUTION INDICATE THAT WHILE ENROLLED THE APPLICANT WAS _____ WAS NOT _____ THE SUBJECT OF DISCIPLINARY ACTION (If applicant was the subject of disciplinary action, please explain on a separate sheet of paper.)

_____
Name of educator - please type or print

_____
Original Signature

_____
Title

_____
Date

(SEAL)

This institution has no seal_____
Signature of educator

Sworn to before me on _____ Commission Number:_____ My commission expires:_____
Date Date

(SEAL)

_____
Notary Signature

ALLIEDONE(12/99)