FORM #3 (Allied)

**OKLAHOMA STATE BOARD OF**
**MEDICAL LICENSURE AND SUPERVISION**
**PO BOX 18256, OKLAHOMA CITY, OK 73154**
**(405) 962-1400**

VERIFICATION OF LICENSURE/CERTIFICATION

THE STATE REGULATORY AGENCY IN EACH STATE WHICH YOU HOLD OR EVER HELD A LICENSE TO PRACTICE MUST COMPLETE THIS FORM.

NAME OF APPLICANT_____ LICENSE NUMBER _____

PROFESSION FOR WHICH LICENSE/CERTIFICATE WAS ISSUED_____

NAME OF STATE ISSUING LICENSE/CERTIFICATE_____

DATE ISSUED _____ CURRENT ☐ NOT CURRENT ☐

IF NOT CURRENT, EXPLAIN BRIEFLY WHY NOT _____

_____

DATES OF DISCIPLINARY ACTION (if applicable) _____

REASON FOR DISCIPLINARY ACTION _____

LICENSE ISSUED ON THE BASIS OF_____

I HEREBY CERTIFY THAT THIS INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND THAT BASED ON RECORDS AVAILABLE TO ME THE APPLICANT WAS COMPETENT TO PRACTICE WHILE LICENSED/CERTIFIED IN THIS STATE

_____
Name of official of agency

_____
Original Signature

_____
Title

_____
Date

(SEAL)

ALLIEDTHREE(10/01)