

**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)