FORM #2 (Allied)

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

VERIFICATION OF PROFESSIONAL TRAINING

THIS FORM MUST BE COMPLETED BY AN OFFICIAL OR INSTRUCTOR OF THE INSTITUTION IN WHICH TRAINING WAS RECEIVED. IF A CERTIFICATE WAS ISSUED UPON COMPLETION OF TRAINING, ATTACH A COPY OF IT TO THIS FORM, THE SEAL OF THE TRAINING INSTITUTION MUST BE IMPRESSED ON THIS FORM, OR THE STATEMENT AT THE BOTTOM OF THIS FORM MUST BE SIGNED, AND THE SIGNATURE OF THE AUTHOR NOTARIZED.

_____ DO HEREBY CERTIFY THAT
Name of official or instructor

_____ RECEIVED TRAINING AT
Name of Applicant

_____ ,LOCATEDIN
Name of Institution

_____ _____
City **State**

FROM J_____4 TO _____/_____/_____ IN _____
MO. day yr. MO. **day** **year** **Subject, specialty or field of study**

A CERTIFICATE WAS ☐ WAS NOT ☐ ISSUED (If not issued explain briefly why not). I FURTHER CERTIFY THAT BASED ON THE RECORDS OF THIS INSTITUTION, THE APPLICANT MET ALL OF THE TRAINING REQUIREMENTS AND COMPLETED SAID TRAINING.

THE APPLICANT WAS WAS NOT ABLE TO COMMUNICATE EFFECTIVELY WITH CO-WORKERS AND PATIENTS.

_____
Name of official or instructor

_____
Original signature

_____
Titie

_____
Date

(SEAI-)

THIS INSTITUTION HAS NO SEAL _____

Sworn to before me this _____ My commission expires _____
Date **Date**

_____
Notary

ALLIEDI/TWO.P*3 (101795)