

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 IN 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)