

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

_____, LOCATED IN
Name of Institution

_____ City _____ State

FROM _____ TO _____ IN _____
MO. J 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

Title

Date

(SEAL-)

THIS INSTITUTION HAS NO SEAL _____

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

Notary