Form #1 (MD)

Oklahoma State Board of Medical Licensure and Supervision
P.O. Box 18256
Oklahoma City, OK 73154-0256

Send or take this form to the Medical School from which you graduated for verification of your graduation. **This form must be completed and mailed directly to the Board by the Medical School.**

I, _____, DO HEREBY CERTIFY THAT THE APPLICANT,
Name of educator

_____ATTENDED_____
Name of applicant Name of institution

LOCATED IN _____, _____,_____
City State Country

FROM _____ / _____ / _____ TO _____ / _____ / _____
mo. day year mo. day year

AND WAS AWARDED THE DEGREE: _____.

_____

I do hereby certify that, at the time of graduation, there was no suspension, probation or other disciplinary action in effect or pending involving this graduate, and to the best of my knowledge he/she was competent to practice medicine.

_____
Signature (Must be an original signature. Proxy or signature stamp will not be accepted.)

SEAL

_____
Title

_____
Date

If the medical school has no seal, the signature of the author of this form must be notarized.

MDONE (08/02)