FORM #2 (MD)

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

VERIFICATION OF COMPLETED POST-GRADUATE TRAINING

This form must be completed and mailed directly to the Board by the training institution.

NAME OF APPLICANT _____
(type or print)

PROGRAM SPECIALTY--INDICATE ONE (OR TRANSITIONAL)

_____

POST-GRADUATE YEAR LEVEL (circle one) 1 2 3 4 5 6

NAME OF PROGRAM DIRECTOR: _____

NAME OF INSTITUTION SPONSORING PROGRAM_____

_____
(city) (state)

DATE ENTERED: ___/___ /___ DATE COMPLETED: ___/___ /___
mo day yr mo day yr

TYPE OF PROGRAM (check one):
ACGME APPROVED RESIDENCY: ☐ FELLOWSHIP: ☐ INTERNSHIP: ☐
NON-APPROVED RESIDENCY: ☐ CLERKSHIP: ☐ OTHER: ☐
If "OTHER", give brief explanation: _____

_____
(Print or type name of applicant)

_____
(Signature of applicant)

To my knowledge this applicant performed satisfactorily in this program, and there was no disciplinary action outstanding or pending against this applicant. I know of no reason this individual should not be licensed to practice medicine.

_____
(Print or type name of program director)

INSTITUTION
SEAL

_____
(Original signature of program director)

I have information that should be reviewed by the licensing agency in its deliberations leading to licensure.

_____
(Print or type name of program director)

INSTITUTION
SEAL

_____
(Original signature of program director)

MDTWO (08/02)