

# Instructions for Applying for Licensure/Examination/Reinstatement

The information contained herein is vital to the successful completion of your application and timely consideration of your request for licensure/reinstatement. Questions or challenges regarding application requirements should be addressed in writing to the Board Secretary. Lengthy telephone conversations with staff delay the overall ability to process applications. You will be notified, in writing, that your application has been received by the Board Office and of all deficiencies in the application you submitted. You will also be notified how to check the status of your application on our web site: [www.okmedicalboard.org](http://www.okmedicalboard.org). The instructions are for your benefit, designed to reduce the need for requests for information after your application has been submitted. Once your application is complete, Board action can be expected within thirty (30) days.

## A. Options

Applications for licensure may be based on:

1. Endorsement of a current license held in any other state of the United States, Territory of the United States, District of Columbia, or Canada; or
2. Examination.

## B. Reinstatement

An applicant for reinstatement shall meet all requirements in effect at the time reinstatement is requested. Upon receipt of your application and fee, you will be notified in writing what documentation is required to complete your application.

## C. Fees

1. All fees are non-refundable.
2. Fees may be paid by check, money order, cashier's check, credit card (authorization form available on web site) or cash. Checks returned by the payer's financial institution must be replaced by a certified check or money order and include a \$25 returned check processing fee.

Medical License Fee .....	\$500
Temporary License Fee .....	\$250
First Year Post-Graduate Training License Fee .....	\$250
Reprocessing Fee .....	\$125

## D. Examinations

1. Applicants who took the FLEX prior to June 1985 must have passed the examination with a FLEX weighted average of 75 or higher attained in one sitting. Scores that have been "factored" or scores from parts of the examination taken in separate sittings combined to achieve a 75 FLEX weighted average are not acceptable. Scores "rounded off" to achieve a 75 FLEX weighted average are not acceptable.

2. Scores achieved in the two-component FLEX examination must be 75 or higher in each component. Components may have been taken in separate jurisdictions or at separate sittings.

3. The Board will accept the following combinations of the USMLE, NBME, and FLEX examinations:

- a. NBME Part 1 **or** USMLE Step 1 **plus**  
NBME Part 2 **or** USMLE Step 2 **plus**  
NBME Part 3 **or** USMLE Step 3;
- b. FLEX Component 1 **plus** USMLE Step 3; **or**
- c. NBME Part 1 **or** USMLE Step 1 **plus**  
NBME Part 2 **or** USMLE Step 2 **plus** FLEX Component 2.

4. All steps of the licensure examination must be passed within ten (10) years.
5. If using the USMLE examination as the required licensure examination, in order to be eligible for a training license, all applicants must have passed USMLE Step 1 and Step 2. All applicants with a medical school graduation date in 2005 or later must pass USMLE Step 1 **and** USMLE Step 2 Clinical Skills (CS) **and** USMLE Step 2 Clinical Knowledge (CK). Additionally, those with a graduation date prior to 2005 who have not passed the Step 2 CK taken on or before June 30, 2005 must pass the Step 2 CS. When applying for a full, unrestricted medical license, an individual must pass Step 3 in addition to the requirements listed previously.
6. Any applicant who fails any part of a licensing examination three times is not eligible for a license. A score of incomplete is considered a failing score. If a combination of NBME, FLEX and/or USMLE is utilized, any applicant who has failed more than six (6) examinations is not eligible for a license. If an applicant has achieved certification by an American Board of Medical Specialties (ABMS) Board, the Board **may** grant an exception.
7. All applicants for initial licensure as a physician and surgeon in Oklahoma shall take and pass with a score of at least 75% a written examination covering medical jurisprudence. The examination shall specifically include, but not be limited to, the Oklahoma Medical Practice Act; Oklahoma Administrative Code; the prescribing, administering and dispensing of medications and controlled dangerous substances; pharmacy law; and licensure procedures. In the event of three failures, the applicant must meet with the Board Secretary in order to devise a study plan prior to taking the examination again. (Exam will be mailed upon receipt of your application.)

## **E. Application and Forms**

1. All sections must be completed to the best of your knowledge. For those items that do not apply to you, mark N/A (Not applicable). If additional space is necessary to respond to any question on the application, attach additional sheets as needed.
2. Any "yes" answer in Section 9 of the application must be explained by a sworn affidavit (a statement signed by the applicant and notarized). **Note: You are required to inform the Board if your response to any of the questions changes after you complete the application and submit it for processing.**
  - (a) Any "yes" answers to those questions concerning previous or current treatment require written releases by the applicant directly to the treatment provider with copies of such releases to accompany the application. The treatment providers should be instructed to provide their responses directly to this office.
  - (b) If you answer "yes" to the question regarding previous arrests, you must provide all available police reports and court documents.
  - (c) You must answer "yes" to questions regarding exam failure if you have failed **any part, step, or component** of a licensure exam including the National Boards, USMLE, FLEX or state licensure exam.
3. A detailed chronological life history from age eighteen years to the present, including education, training, employment, military service, and non-work time must be provided in Sections 12 and 13.
4. Each applicant shall have satisfactorily completed progressive postgraduate training approved by the Board. Graduates of medical schools in the United States shall have twelve (12) months of progressive post-graduate training. Applicants from a foreign medical school shall provide the Board with proof of successful completion of twenty-four (24) months progressive post-graduate medical training, obtained in the same medical specialty, from a program approved by:
  - a. The American Council on Graduate Medical Education (ACGME);
  - b. The Royal College of Physicians and Surgeons of Canada;
  - c. The College of Family Physicians of Canada;
  - d. The Royal College of Physicians of Edinburgh;
  - e. The Royal College of Physicians of England;
  - f. The Royal College of Physicians and Surgeons of Glasgow; or
  - g. The Royal College of Surgeons in Ireland.

5. In Section 8, list all jurisdictions, United States or foreign, in which you are licensed or have applied for licensure to practice medicine and surgery or in which you have been authorized to practice. Also list all jurisdictions, United States or foreign, in which you have been denied authorization to practice or have voluntarily surrendered a license or authorization to practice. **Verification of all licenses or certificates ever held in the United States and/or Canada must be verified on Form #3. Form #3** must contain an original signature and State Board Seal.

6. You must also list all other health care professions in which you have ever been licensed or certified. This must be verified on **Form #3**.

7. Graduates of foreign medical schools must submit a tape-recorded reading of a written selection created by the Board and evaluated by the Secretary as to the ability of the applicant to communicate in the English language or take an oral examination as determined by the Board. Additional information will be sent upon receipt of application.

8. All education, training and examination must be verified. **Please mark the box next to your choice for process of verification.**

You may contact the Federation Credentials Verification Service (FCVS) and obtain the appropriate application and forms for them to verify your information.

\_\_\_\_\_ FCVS  
PO Box 619850  
Dallas, TX 75261-9850  
Phone: (817) 868-4000

**OR**

\_\_\_\_\_ You may verify all data by submitting the following:

#### **PRE-MEDICAL SCHOOL**

Official transcripts from all educational institutions attended (after high school) must be submitted in a sealed envelope directly from the institution.

#### **MEDICAL SCHOOL**

Graduation from medical school must be verified by submitting **Form #1, Verification of Education**. The completed form must be submitted directly to the Board by the school. An official transcript of grades with degree posted must be submitted in a sealed envelope directly from the institution.

#### **POST-GRADUATE TRAINING**

All completed training must be verified by submitting **Form #2, Verification of Post-Graduate Training** (signed by the program director and impressed with the institution's seal), submitted directly to the Board by the institution. All current training must be verified by submitting **Form #5, Verification of Current Post-Graduate Training** (signed by the program director and impressed with the institution's seal), submitted directly to the Board by the institution. Applicants for a special license to begin post-graduate training must have their prospective program complete the Form #5 to verify acceptance into the program.

#### **ENGLISH PROFICIENCY EXAMINATION (FOREIGN MEDICAL SCHOOL GRADUATES)**

Graduates of foreign medical schools whose documents are not printed in the English language shall provide original translations. United States Consulates and formal foreign language education programs accredited by the North Central Association of Colleges and Schools are approved to provide translations to the Board. An applicant may request to use another translator. Such a request must be made in writing and include the proposed translator's name, address and qualifications to support the approval of the request. Both the applicant and the translator shall attest to the accuracy of the translation.

#### **IMMIGRATION STATUS (FOREIGN MEDICAL SCHOOL GRADUATES)**

A foreign applicant shall provide the Board with written proof of his/her ability to work in the United States as authorized by the United States Citizenship and Immigration Service (USCIS).

### **ECFMG VERIFICATION (FOREIGN MEDICAL SCHOOL GRADUATES)**

Graduates of foreign medical schools must provide verification of ECFMG certification. You may obtain the request form from ECFMG at [www.ecfm.org](http://www.ecfm.org) or from our office.

### **CLERKSHIPS (FOREIGN MEDICAL SCHOOL GRADUATES)**

Effective January 1, 2004, an applicant that graduated from a foreign medical school after July 1, 2003 who completed clerkships in the United States, its territories or possessions, must have done the clerkships in hospitals or schools that have programs accredited by the Accreditation Council for Graduate Medical Education (ACGME). A foreign medical school graduate who did clerkships in the United States must provide documentation regarding the clerkships. Every clerkship must be verified by submitting a completed **Form #4, Verification of Clinical Clerkship** (signed by the program director or instructor and impressed with the institution's seal).

### **LICENSING EXAMINATIONS**

Applicants must request that test scores be submitted to the Board directly from the Federation of State Medical Boards or the National Board of Medical Examiners, depending on the type of examination taken. (Please note that there is normally a fee charged in order for your scores to be sent.)

The addresses for requesting these are:

(For National Board Scores)  
National Board of Medical Examiners  
PO Box 48014  
Newark, NJ 07101-4814  
(215) 590-9500  
[www.nbme.org](http://www.nbme.org)

(For FLEX or USMLE Scores)  
Federation of State Medical Boards  
400 Fuller Wisser Road  
Euless, TX 76039-3855  
(817) 868-4000  
[www.fsmb.org](http://www.fsmb.org)

### **F. Extended Background Check**

Effective **July 1, 2006** all applicants for licensure will be required to request an **Extended Background Check (EBC)** by completing the enclosed EBC Authorization Form and submitting it with the applicable fee (see form) to Trak-1 Technology (address on form).

### **G. Temporary Licensure (59 O.S., Section 493.3)**

The Board may authorize the Secretary to issue a Temporary Medical License for the intervals between Board meetings. Such Temporary License shall be granted only when the Secretary is satisfied as to the qualifications of the applicant to be licensed under this Act but where such qualifications have not been verified to the Board. Such a license shall:

1. Be granted only to an applicant demonstrably qualified for a full and unrestricted medical license;
2. Automatically terminate on the date of the next Board meeting at which the applicant may be considered for a full and unrestricted medical license.

An application for Temporary Licensure must be made by written request and include all appropriate fees.

**NOTE:** We must be in receipt of your examination scores in order for the Board Secretary to consider issuing a Temporary License.

## H. General Application Process

1. This office may contact other sources for verification of information contained in your application. Your application will not be considered complete until the EBC and all other requests for verification have been received.
2. Once complete, applications are circularized to Board members for consideration. If all Board members approve the application, a license may be issued. Should one or more Board member fail to approve on circularization, the application will be reviewed during the next regularly scheduled business meeting of the Board. Applications are not denied on circularization. The applicant will be notified if the application has been held and given the opportunity to meet with the Board to discuss his/her application.
3. Even though an application is complete and all requirements are satisfied, there is no guarantee that the Board will grant licensure. The Board may find exceptions or make discoveries that will cause them not to approve an application. In such an event, the Board will clearly state the basis upon which such exceptions have been made. The Board may, at its discretion, require further proof of clinical competency.
4. There is no way to determine how soon you will receive notification of a Board decision after you submit an application. Even though we feel the instructions and applications are thorough, should you have questions, you may contact the Licensing Department at (405) 962-1400.
5. We will send you a copy of the Board of Medical Licensure and Supervision Handbook upon receipt of your application. The Handbook contains the Oklahoma Allopathic Medical and Surgical Licensure and Supervision Act, Oklahoma Administrative Code, information regarding Continuing Medical Education (CME) requirements, and other information regarding medical licensure in Oklahoma. You may also obtain this information from our web site: [www.okmedicalboard.org](http://www.okmedicalboard.org).

## I. Definitions

- "**Act**" means the Oklahoma Allopathic Medical and Surgical Licensure and Supervision Act, 59 O.S. §480 et seq.  
"**APA**" means either or both Article I and Article II, as applicable, of the Administrative Procedures Act, 75 O.S. 1991, §250 et seq., as amended.  
"**Applicant**" means a person who applies for licensure from the Board.  
"**Board**" means the Oklahoma State Board of Medical Licensure and Supervision.  
"**Foreign applicant**" means an applicant who is a graduate of a foreign medical school.  
"**Foreign medical school**" means a medical school located outside of the United States.  
"**Secretary**" means the Secretary of the Board.

**I, the undersigned, have fully read and understand the instructions. I swear or affirm that the information submitted in and with the application is, to the best of my knowledge, true and factual. I understand that attempts to deceive or fraudulently portray information contained herein may result in cancellation of my application or charges of filing a fraudulent application that may result in subsequent revocation of licensure.**

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Applicant (type or print)

**Please return these instructions, signed, with your application to:**

OSBMLS  
PO Box 18256                      or  
Oklahoma City OK 73154-0256

OSBMLS  
101 NE 51<sup>st</sup> Street  
Oklahoma City, OK 73105

**OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION  
P.O. BOX 18256  
OKLAHOMA CITY, OK 73154-0256**

**APPLICATION FOR LICENSURE BY ENDORSEMENT \_\_\_\_\_ EXAMINATION \_\_\_\_\_  
REINSTATEMENT \_\_\_\_\_**

PRINT OR TYPE ANSWERS TO ALL QUESTIONS ON THIS FORM. IF NOT APPLICABLE, MUST PUT N/A.

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**1.**  
LAST NAME: \_\_\_\_\_ MAILING ADDRESS: \_\_\_\_\_  
FIRST NAME: \_\_\_\_\_ STREET / P.O. BOX: \_\_\_\_\_  
MIDDLE NAME: \_\_\_\_\_ CITY: \_\_\_\_\_  
SUFFIX: \_\_\_\_\_ SOC. SEC. NUMBER: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

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PRACTICE NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
PHONE NUMBER: \_\_\_\_\_

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**2. LIST ALL OTHER NAMES USED AND PROVIDE NOTARIZED COPIES OF DOCUMENTATION TO SUPPORT NAME CHANGE(S): (Use additional paper as needed)**

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**3. DATE AND PLACE OF BIRTH:**  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ COUNTRY \_\_\_\_\_  
Mo. Day Yr.

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**4. ETHNIC ORIGIN: CAUCASIAN \_\_\_\_\_ BLACK \_\_\_\_\_ AM. INDIAN \_\_\_\_\_ HISPANIC \_\_\_\_\_ OTHER(SPECIFY) \_\_\_\_\_**  
SEX: (M/F) \_\_\_\_\_

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**5. MILITARY SERVICE**  
BRANCH: \_\_\_\_\_ RANK: \_\_\_\_\_ FROM: \_\_\_\_/\_\_\_\_/\_\_\_\_ TO: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MO DAY YEAR MO DAY YEAR

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**DO NOT WRITE BELOW THIS LINE - FOR OFFICE USE ONLY**

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APPLICATION RECEIVED \_\_\_\_\_ DATE APPROVED \_\_\_\_\_

FEE RECEIVED \_\_\_\_\_ FEE AMOUNT \_\_\_\_\_

COMMENTS: \_\_\_\_\_

6. **SPECIALTY INFORMATION**

a. PRIMARY SPECIALTY: 1. \_\_\_\_\_  
SECONDARY SPECIALTIES: 2. \_\_\_\_\_ 3. \_\_\_\_\_

b. LIST CURRENT CERTIFICATION(S) BY **ABMS** SPECIALTY BOARD(S):

(1) \_\_\_\_\_  
(2) \_\_\_\_\_

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7. **EXAMINATIONS**

**Indicate number of times each examination was taken:** (include examinations for ECFMG Certification)

National Boards: Part I \_\_\_\_\_ Part II \_\_\_\_\_ Part III \_\_\_\_\_  
FLEX Part I \_\_\_\_\_ Part II \_\_\_\_\_ Part III \_\_\_\_\_ Component I \_\_\_\_\_ Component II \_\_\_\_\_  
USMLE Step 1 \_\_\_\_\_ Step 2 \_\_\_\_\_ Step 2(CK) \_\_\_\_\_ Step 2(CS) \_\_\_\_\_ Step 3 \_\_\_\_\_  
SPEX \_\_\_\_\_  
State Board \_\_\_\_\_ (which state? \_\_\_\_\_)

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8. **LICENSURE**

A. LIST ALL JURISDICTIONS, U.S. OR FOREIGN, IN WHICH YOU ARE LICENSED OR HAVE APPLIED FOR LICENSURE OR IN WHICH YOU ARE OR WERE PREVIOUSLY LICENSED, AUTHORIZED TO PRACTICE OR UNDERGO POST-GRADUATE TRAINING (INLCUDE ALL TRAINING LICENSES/PERMITS, TEMPORARY LICENSES, LIMITED LICENSES, ETC.):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

B. LIST ALL JURISDICTIONS, U.S. OR FOREIGN, IN WHICH YOU HAVE BEEN DENIED LICENSURE, WITHDRAWN AN APPLICATION FOR LICENSURE OR HAVE VOLUNTARILY SURRENDERED A LICENSE:

\_\_\_\_\_

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C. HAVE YOU EVER BEEN LICENSED/CERTIFIED IN ANY OTHER PROFESSION(S)? (Use additional paper if needed.)

(1) PROFESSION: \_\_\_\_\_ DATE ISSUED: \_\_\_\_\_ STATE \_\_\_\_\_  
(2) PROFESSION: \_\_\_\_\_ DATE ISSUED: \_\_\_\_\_ STATE \_\_\_\_\_  
(3) PROFESSION: \_\_\_\_\_ DATE ISSUED: \_\_\_\_\_ STATE \_\_\_\_\_  
(4) PROFESSION: \_\_\_\_\_ DATE ISSUED: \_\_\_\_\_ STATE \_\_\_\_\_

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9. ANSWER THE FOLLOWING QUESTIONS. "YES" ANSWERS MUST BE EXPLAINED IN A SWORN AFFIDAVIT. **NOTE:** THE INFORMATION YOU ARE ABOUT TO GIVE MAY BE INCLUDED IN ADMINISTRATIVE, CIVIL OR CRIMINAL PROCEEDINGS.

*\*The following words and terms, when used in this section, shall have the following meaning:*

*"Disciplinary Action" means any adverse action and includes but is not limited to revocation, suspension, probation, stipulations, limitations, restrictions, conditions, censure, reprimand.*

*"License" means any professional license and includes but is not limited to permits, temporary licenses, limited licenses, institutional licenses, training licenses/permits/certificates.*

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A. Has your application for examination or a license ever been denied? YES \_\_\_ NO \_\_\_

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B. Have you ever failed **any part** of an examination (FLEX, USMLE, NBME, ECFMG, STATE EXAM)? YES \_\_\_ NO \_\_\_

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C. Have you ever surrendered a license or had a license revoked? YES \_\_\_ NO \_\_\_

Has any disciplinary action been taken on any license? YES \_\_\_ NO \_\_\_

Have you ever been requested to appear before a licensing or disciplinary agency? YES \_\_\_ NO \_\_\_

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D. Have you ever been arrested, charged with, or convicted of a felony or misdemeanor, other than traffic violations? YES \_\_\_ NO \_\_\_

Have you been arrested, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance, including alcohol? YES \_\_\_ NO \_\_\_

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E. Are you now or have you within the past two years been addicted to or used in excess any drug or chemical substance, including alcohol? YES \_\_\_ NO \_\_\_

Have you obtained an assessment or been treated for the use of any drug or chemical substance, including alcohol? YES \_\_\_ NO \_\_\_

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F. Do you currently have or have you had within the past two years any mental or physical disorder or condition which, if untreated, could affect your ability to practice competently? YES \_\_\_ NO \_\_\_

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G. Have you ever been denied provider participation, terminated, sanctioned, or penalized by any third party payor, to include **TRICARE, MEDICARE, MEDICAID**? YES \_\_\_ NO \_\_\_

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H. Have you ever surrendered or had any adverse action taken against any narcotic permit (state or federal)? YES \_\_\_ NO \_\_\_

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I. Have you ever been denied membership or had disciplinary action taken by a national, state or county medical organization? YES \_\_\_ NO \_\_\_

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J. Have you ever been denied or had removed or suspended hospital staff privileges? YES \_\_\_ NO \_\_\_

Have you ever surrendered hospital staff privileges while under investigation or to avoid investigation? YES \_\_\_ NO \_\_\_

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K. Have you ever entered into an agreement with a federal, state or local jurisdictional body to avoid formal action? YES \_\_\_ NO \_\_\_

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L. Have you ever been the subject of an investigation or disciplinary action by a hospital, clinic, practice group, residency program or professional school? YES \_\_\_ NO \_\_\_

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M. Have you had any adverse judgment, settlement, or award against you arising from a professional liability claim? YES \_\_\_ NO \_\_\_

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N. Have you ever had professional liability coverage declined, canceled, issued on special terms, or renewal refused? YES \_\_\_ NO \_\_\_

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O. Have you ever been reported to the National Practitioners Data Bank (NPDB) or to the Healthcare Integrity and Protection Data Bank (HIPDB)? YES \_\_\_ NO \_\_\_

10.  
IF LICENSED, WHERE DO YOU INTEND TO LOCATE?

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WHY DO YOU SEEK LICENSURE IN THE STATE OF OKLAHOMA?

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HAVE YOU EXECUTED OR BEEN OFFERED A CONTRACT IN CONNECTION WITH PRACTICE IN THE STATE OF OKLAHOMA?  
IF SO, PLEASE IDENTIFY WITH WHICH CATEGORY:

HOSPITAL \_\_\_\_\_ ESTABLISHED PRACTICE \_\_\_\_\_

HEALTH CARE CORPORATION (HMO, PPO, IPA, etc.) \_\_\_\_\_

OTHER: \_\_\_\_\_

**PROFESSIONAL LIABILITY INSURANCE:**

1. NAME OF PREVIOUS CARRIER AND POLICY HOLDER: \_\_\_\_\_

2. NAME OF CURRENT CARRIER AND POLICY HOLDER: \_\_\_\_\_

3. WILL YOUR PROFESSIONAL LIABILITY INSURANCE POLICY COVER YOUR PRACTICE IN OKLAHOMA? \_\_\_\_\_

4. IF NOT, WHEN DO YOU EXPECT TO OBTAIN LIABILITY INSURANCE THAT WILL COVER PRACTICE IN OKLAHOMA?

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**11. TEACHING APPOINTMENTS**

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Institution	City/State	Appointment	Date
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Institution	City/State	Appointment	Date
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Institution	City/State	Appointment	Date
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12.

**EDUCATION**

**POST-GRADUATE MEDICAL TRAINING**

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HIGH SCHOOL: \_\_\_\_\_ HOSPITAL: \_\_\_\_\_

CITY: \_\_\_\_\_ CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ COUNTRY: \_\_\_\_\_ STATE: \_\_\_\_\_ COUNTRY: \_\_\_\_\_

MO/YR MO/YR MO/YR MO/YR  
ENTERED: \_\_\_\_/\_\_\_\_ DEPARTED: \_\_\_\_/\_\_\_\_ ENTERED: \_\_\_\_/\_\_\_\_ DEPARTED: \_\_\_\_/\_\_\_\_

SPECIALTY: \_\_\_\_\_

PRE-MEDICAL: \_\_\_\_\_ HOSPITAL: \_\_\_\_\_

CITY: \_\_\_\_\_ CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ COUNTRY: \_\_\_\_\_ STATE: \_\_\_\_\_ COUNTRY: \_\_\_\_\_

MO/YR MO/YR MO/YR MO/YR  
ENTERED: \_\_\_\_/\_\_\_\_ DEPARTED: \_\_\_\_/\_\_\_\_ ENTERED: \_\_\_\_/\_\_\_\_ DEPARTED: \_\_\_\_/\_\_\_\_

TYPE DEGREE: \_\_\_\_\_ SPECIALTY: \_\_\_\_\_

PRE-MEDICAL: \_\_\_\_\_ HOSPITAL: \_\_\_\_\_

CITY: \_\_\_\_\_ CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ COUNTRY: \_\_\_\_\_ STATE: \_\_\_\_\_ COUNTRY: \_\_\_\_\_

MO/YR MO/YR MO/YR MO/YR  
ENTERED: \_\_\_\_/\_\_\_\_ DEPARTED: \_\_\_\_/\_\_\_\_ ENTERED: \_\_\_\_/\_\_\_\_ DEPARTED: \_\_\_\_/\_\_\_\_

TYPE DEGREE: \_\_\_\_\_ SPECIALTY: \_\_\_\_\_

MEDICAL SCHOOL: \_\_\_\_\_ HOSPITAL: \_\_\_\_\_

CITY: \_\_\_\_\_ CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ COUNTRY: \_\_\_\_\_ STATE: \_\_\_\_\_ COUNTRY: \_\_\_\_\_

MO/YR MO/YR MO/YR MO/YR  
ENTERED: \_\_\_\_/\_\_\_\_ DEPARTED: \_\_\_\_/\_\_\_\_ ENTERED: \_\_\_\_/\_\_\_\_ DEPARTED: \_\_\_\_/\_\_\_\_

TYPE DEGREE: \_\_\_\_\_ SPECIALTY: \_\_\_\_\_

MEDICAL SCHOOL: \_\_\_\_\_ HOSPITAL: \_\_\_\_\_

CITY: \_\_\_\_\_ CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ COUNTRY: \_\_\_\_\_ STATE: \_\_\_\_\_ COUNTRY: \_\_\_\_\_

MO/YR MO/YR MO/YR MO/YR  
ENTERED: \_\_\_\_/\_\_\_\_ DEPARTED: \_\_\_\_/\_\_\_\_ ENTERED: \_\_\_\_/\_\_\_\_ DEPARTED: \_\_\_\_/\_\_\_\_

TYPE DEGREE: \_\_\_\_\_ SPECIALTY: \_\_\_\_\_



14. PHOTOGRAPH

MOUNT PHOTOGRAPH HERE  
IMPORTANT: AFFIX NOTARY SEAL  
PARTIALLY ON THE PHOTO AND  
PARTIALLY ON THE APPLICATION

THIS PHOTOGRAPH, TAKEN WITHIN THE PAST  
TWELVE MONTHS, IS A CORRECT LIKENESS OF  
MYSELF.

\_\_\_\_\_  
APPLICANT SIGNATURE

\_\_\_\_\_  
NOTARY SIGNATURE

COMMISSION NUMBER: \_\_\_\_\_

MY COMMISSION EXPIRES: \_\_\_\_\_

I, \_\_\_\_\_, hereby certify under oath that I am the person named in the application for license to practice medicine and surgery in the State of Oklahoma, that all statements I have made herein are true; that the photograph is a true resemblance of me and was made within the last 12 months; that in consideration of the issuance to me of a license to practice medicine and surgery in the State of Oklahoma I hereby pledge that I shall abstain from deceptive or fraudulent methods of practice, from immoral, unprofessional and unethical conduct; I shall abstain from professional association with, and shall not act as a shield for, an unlicensed practitioner or other person and I hereby agree that violation of this pledge shall constitute cause for the revocation of my medical license.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present) and all government agencies (local, state, federal or foreign) to release to the Oklahoma State Board of Medical Licensure and Supervision or its successors any information, files or records requested by that Board in connection with this application. I further authorize the Oklahoma State Board of Medical Licensure and Supervision or its successors to release to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure or licensure renewal.

\_\_\_\_\_, M.D.  
APPLICANT'S SIGNATURE

SUBSCRIBED AND SWORN TO BEFORE ME THIS \_\_\_\_\_ DAY OF \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
NOTARY PUBLIC

SEAL

COMMISSION NUMBER: \_\_\_\_\_

MY COMMISSION EXPIRES: \_\_\_\_\_