

**OKLAHOMA STATE BOARD OF
MEDICAL LICENSURE AND SUPERVISION
PO BOX 18256, OKLAHOMA CITY, OK 73154
(405) 962-1400**

VERIFICATION OF EDUCATION

AN EDUCATOR OF THE INSTITUTION FROM WHICH YOU OBTAINED YOUR PROFESSIONAL ACADEMIC DEGREE/CERTIFICATE MUST COMPLETE THIS FORM. THE SEAL OF THE INSTITUTION MUST BE IMPRESSED ON THIS FORM OR THE STATEMENT AT THE BOTTOM OF THIS FORM MUST BE SIGNED BY THE AUTHOR OF THIS FORM AND THE SIGNATURE NOTORIZED. ALL SIGNATURES MUST BE ORIGINAL.

I, _____, DO HEREBY CERTIFY THAT THE APPLICANT,

Name of educator

ATTENDED _____

Name of applicant

Name of institution

LOCATED IN _____, _____, FROM ____ / ____ / ____ TO ____ / ____ / ____ **
City State mo. day year mo. day year

AND WAS AWARDED THE DEGREE/CERTIFICATE OF _____.

****For graduates with a graduation date after July 1, 2007, I certify that the completed program consisted of at least one year of classroom instruction and one year of clinical experience that included a minimum of one month each in family medicine, emergency medicine and surgery.**

A TRUE COPY OF THE DIPLOMA/CERTIFICATE AWARDED IS ____ IS NOT ____ ATTACHED (If not attached, explain briefly why not)

RECORDS OF THIS INSTITUTION INDICATE THAT WHILE ENROLLED THE APPLICANT WAS ____ WAS NOT ____ THE SUBJECT OF DISCIPLINARY ACTION (If applicant was the subject of disciplinary action, please explain on a separate sheet of paper.)

Name of educator - please type or print

Original Signature

Title

Date

(SEAL)

This institution has no seal _____
Signature of educator

Sworn to before me on _____ Commission Number: _____ My commission expires: _____
Date Date

(SEAL)

Notary Signature