

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

NOTICE TO PHYSICIAN ASSISTANTS

IT IS MANDATORY THAT THIS DOCUMENT, PROPERLY EXECUTED, BE SUBMITTED TO THE STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION PRIOR TO APPROVAL FOR PRACTICE TEMPORARILY BY THE SECRETARY OF THE STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION.

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I, \_\_\_\_\_(M.D.) (D.O.)  
Name of primary Supervising Physician - Type or print

LICENSE NUMBER: \_\_\_\_\_, CERTIFY THAT I AM PRIMARY SUPERVISING PHYSICIAN FOR THE FOLLOWING PHYSICIAN ASSISTANT(S) ONLY:

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

I FURTHER CERTIFY THAT I AM ALTERNATE SUPERVISING PHYSICIAN FOR THE FOLLOWING PHYSICIAN ASSISTANT(S):

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

\_\_\_\_\_  
Date (mm/dd/yy)

\_\_\_\_\_  
Signature of Physician