

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION
P.O. Box 18256 Oklahoma City, OK 73154-0256 (405) 962-1400

I AM APPLYING FOR LICENSURE IN THE FOLLOWING PROFESSION: (Check appropriate line)

- | | | |
|--|---|--|
| <input type="checkbox"/> Respiratory Care Practitioner | <input type="checkbox"/> Physician Assistant | <input type="checkbox"/> Licensed Dietitian |
| <input type="checkbox"/> Provisional Respiratory Care Practitioner | <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Provisional Licensed Dietitian |
| <input type="checkbox"/> Podiatrist | <input type="checkbox"/> Physical Therapist Assistant | <input type="checkbox"/> Registered Electrologist |
| <input type="checkbox"/> Orthotist | <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Athletic Trainer |
| <input type="checkbox"/> Technician (Prosthetist and/or Orthotist) | <input type="checkbox"/> Occupational Therapy Assistant | <input type="checkbox"/> Apprentice Athletic Trainer |
| <input type="checkbox"/> Radiologist Assistant | <input type="checkbox"/> Prosthetist | <input type="checkbox"/> Prosthetist/Orthotist |
| | <input type="checkbox"/> Assistant (Prosthetist and/or Orthotist) | |
| | <input type="checkbox"/> Anesthesiologist Assistant | <input type="checkbox"/> Therapeutic Recreation Specialist |

I passed an examination for licensure/certification on _____

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

=====

LAST NAME: _____ MAILING ADDRESS: _____

FIRST NAME: _____ STREET / P.O. BOX: _____

MIDDLE NAME: _____ CITY: _____

SUFFIX: _____ SOC. SEC. NUMBER: _____ STATE: _____ ZIP: _____

=====

PRACTICE NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ TELEPHONE NUMBER _____

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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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DATE AND PLACE OF BIRTH: _____

_____/_____/_____ CITY _____ STATE _____ COUNTRY _____

Mo. Day Yr.

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ETHNIC ORIGIN: CAUCASIAN _____ BLACK _____ AMERICAN INDIAN _____ HISPANIC _____ OTHER(SPECIFY) _____

SEX: (M/F) _____

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MILITARY SERVICE

BRANCH: _____ RANK: _____ FROM: ____/____/____ TO: ____/____/____

MO DAY YEAR MO DAY YEAR

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HAVE YOU EVER BEEN LICENSED IN THE STATE OF OKLAHOMA? _____ (1) PROFESSION(S): _____

(2) DATE(S) ISSUED: _____

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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: _____

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 registrations, certifications, permits, temporary licenses, limited licenses, institutional licenses, and/or training licenses/permits/certificates.

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

B. Have you ever failed **any part** of a licensure/certification/registration examination? YES ___ NO ___

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 ___

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 ___

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 ___

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 ___

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

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

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

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 ___

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

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

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

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

O. Have you ever been reported to the National Practitioners Data Bank (NPDB) or to the Healthcare Integrity and Protection Data Bank (HIPDB)? (If yes, enclose a copy of the report.) YES ___ NO ___

PHOTOGRAPH

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

SEAL

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

APPLICANT SIGNATURE

NOTARY SIGNATURE

COMMISSION NUMBER: _____

MY COMMISSION EXPIRES: _____

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 I, _____, hereby certify under oath or affirmation, that I am the person named in this application for license to practice as a (profession) _____ in the State of Oklahoma; that all statements I have made herein are true; that I am the original and lawful possessor of the required credentials for licensure; 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 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 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 the 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.

(SEAL)

APPLICANT'S SIGNATURE

SWORN TO BEFORE ME: _____

NOTARY PUBLIC

COMMISSION NUMBER: _____

MY COMMISSION EXPIRES: _____