

Oklahoma Board of Medical Licensure and Supervision

101 NE 51st Street, Oklahoma City, OK 73105

PO Box 18256, Oklahoma City, OK 73154-0256

Main Number – (405)-962-1400 Ext. 118 Fax – 405-962-1499

Request for Public Information – Please print out and mail or fax

I, the undersigned, hereby request the following information:

Check the appropriate boxes:

Data Format:

<input type="checkbox"/>	Comma Delimited Text
<input type="checkbox"/>	Excel Format

Delivery Method:

<input type="checkbox"/>	E-Mail
<input type="checkbox"/>	CD-ROM

Choose Profession(s): (\$120 total for all professions listed below)

<input checked="" type="checkbox"/>	<i>Code</i>	<i>Description</i>	<input checked="" type="checkbox"/>	<i>Code</i>	<i>Description</i>
<input type="checkbox"/>	AA	Apprentice Athletic Trainer	<input type="checkbox"/>	PT	Physical Therapist
<input type="checkbox"/>	AT	Licensed Athletic Trainer	<input type="checkbox"/>	TA	Physical therapists Assistant
<input type="checkbox"/>	MD	Medical Doctor	<input type="checkbox"/>	LD	Licensed Dietitian
<input type="checkbox"/>	PA	Physician Assistant	<input type="checkbox"/>	PD	Provisionally Licensed Dietitian
<input type="checkbox"/>	OT	Occupational Therapists	<input type="checkbox"/>	RC	Respiratory care Practitioner
<input type="checkbox"/>	OA	Occupational Therapy Assistant	<input type="checkbox"/>	PR	Provisional Respiratory Care Practitioner
<input type="checkbox"/>	RE	Registered Electrologist	<input type="checkbox"/>	RPOA	Registered Prosthetist/Orthotist Assistant
<input type="checkbox"/>	LPED	Licensed Pedorthist	<input type="checkbox"/>	ROA	Registered Orthotist Assistant
<input type="checkbox"/>	LPO	Licensed Prosthetist/Orthotist	<input type="checkbox"/>	RTO	Registered Technician – Orthotic
<input type="checkbox"/>	LPR	Licensed Prosthetist	<input type="checkbox"/>	RTP	Registered Technician – Prosthetic
<input type="checkbox"/>	LO	Licensed Orthotist	<input type="checkbox"/>	RTPO	Registered Technician – Prosthetic/ Orthotic
<input type="checkbox"/>	RPA	Registered Prosthetist Assistant	<input type="checkbox"/>	ANA	Anesthesiologist Assistants
<input type="checkbox"/>	RA	Radiologist Assistants	<input type="checkbox"/>		

The Following Professions require additional charges of \$100 for each report:

<input type="checkbox"/>	POD	Podiatrist	<input type="checkbox"/>	LP	Licensed Perfusionist
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Check here for separate files per profession requested.

Choose License Status: (check all that apply)

Active

Inactive*

(*This will include outdated licensees)

Personal Data/Mailing Info:

<input checked="" type="checkbox"/>	<i>Description</i>	<i>Sort BY:</i>	<input checked="" type="checkbox"/>	<i>Description</i>	<i>Sort BY:</i>
<input type="checkbox"/>	First Name		<input type="checkbox"/>	Complete Mailing Address	
<input type="checkbox"/>	Middle Name		<input type="checkbox"/>	• Address Line 1	
<input type="checkbox"/>	Last Name		<input type="checkbox"/>	• Address Line 2	
<input type="checkbox"/>	Suffix (Jr., III)		<input type="checkbox"/>	• Address Line 3	
<input type="checkbox"/>	Birth Date		<input type="checkbox"/>	• City	
<input type="checkbox"/>	Birth City		<input type="checkbox"/>	• State	
<input type="checkbox"/>	Birth Country		<input type="checkbox"/>	• Zip Code	
<input type="checkbox"/>	Gender (M, F)		<input type="checkbox"/>	• Province (Non USA)	
<input type="checkbox"/>	Race		<input type="checkbox"/>	• Country	
<input type="checkbox"/>			<input type="checkbox"/>	• County	

Internal Use Only (Shipped to)

Contact:	Payment Amount/Method:
Company Name:	Total Hours:
Email Address:	File Name:
Delivery Date and Method:	Completed by:

DO NOT EMAIL THIS FORM
PRINT AND MAIL OR FAX

Practice Address:

✓	Description	Sort BY:	✓	Description	Sort BY:
	Complete Practice Address			• State	
	• Address Line 1			• Zip Code	
	• Address Line 2			• Province (Non USA)	
	• Address Line 3			• Country	
	• City			• Practice County	
				• Practice Phone Number	

License Information:

✓	Description	Sort BY:	✓	Description	Sort BY:
	License Number			Endorsed By	
	License Issue Date			Supervisor Types (Non-MD Only)	
	License Expiration Date			Supervisor License Number (Non-MD Only)	
	License Status (Active, Inactive)			Supervisor Name (Non-MD Only)	
	Status Class			Specialty 1 (MD Only) – Primary	
	Board Certification 1 (MD Only)			Specialty 2 (MD Only)	
	Board Certification 2 (MD Only)			Specialty 3 (MD Only)	
	Board Certification 3 (MD Only)			Specialty 4 (MD Only)	
				Specialty 5 (MD Only)	
"Requesting Disciplinary Action and/or Disciplinary Remarks will result in multiple records per license"					
	Disciplinary Action			Discipline Remarks	
	Disciplinary Date				

Education:

(Requesting Education information will result in multiple records per licensee).

(One record for each school entry)

✓	Description	✓	Description
	High School or Undergraduate School Name		Post Graduate School Name
	High School or Undergraduate School City		Post Graduate School City
	High School or Undergraduate School State		Post Graduate School State
	High School or Undergraduate School Country		Post Graduate School Country
	High School or Undergraduate School From Month		Post Graduate School From Month
	High School or Undergraduate School From Year		Post Graduate School From Year
	High School or Undergraduate School To Month		Post Graduate School To Month
	High School or Undergraduate School To Year		Post Graduate School To Year
	High School or Undergraduate School Degree Received		Post Graduate School Degree
	Medical School Name		Medical School City
	Medical School From Month		Medical School Country
	Medical School To Month		Medical School From Year
	Medical School Degree		Medical School To Year

Additional Information

Internal Use Only

Contact:	City, State, Zip:
Company Name:	Phone: Ext.
Address Line 1:	Fax:
Address Line2:	Email: Address:

DO **NOT** EMAIL THIS FORM
PRINT AND MAIL OR FAX

Please Type

Ship To:

Name			
Company Name			
Address Line 1			
Address Line 2			
Address Line 3			
City, State, ZIP			
Phone		Ext.#	
Fax		Ext.#	
E-Mail Address			

Method of Payment

(Check on one):

Check (Enclosed)

Bill Pay (Credit Card Payment)
(www.okmedicalboard.org) tab in the middle of the screen.

Enter Bill Pay Authorization Number

Requestor's Signature: _____ **Date:** _____