FORM #3 (Allied)

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

VERIFICATION OF LICENSURE/CERTIFICATION

THE STATE REGULATORY AGENCY IN EACH STATE WHICH YOU HOLD OR EVER HELD A LICENSE TO PRACTICE MUST COMPLETE THIS FORM.

NAME OF APPLICANT__________________________________ **LICENSE NUMBER** _______________

PROFESSION IN WHICH LICENSE/CERTIFICATE WAS ISSUED______________________________

NAME OF STATE ISSUING LICENSE/CERTIFICATE____

DATE ISSUED _______________________ **CURRENT** ____________ **NOT CURRENT** ______________

IF NOT CURRENT, EXPLAIN BRIEFLY WHY NOT :

DATES OF DISCIPLINARY ACTION (if applicable) ____

REASON FOR DISCIPLINARY ACTION ____

LICENSE ISSUED ON THE BASIS OF____

I HEREBY CERTIFY THAT THIS INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND THAT BASED ON RECORDS AVAILABLE TO ME THE APPLICANT WAS COMPETENT TO PRACTICE WHILE LICENSED/CERTIFIED IN THIS STATE

____
Name of official of agency

____
Original Signature

____
Title

____
Date

(SEAL)

ALLIEDTHREE(10/01)