OKLAHOMA STATE BOARD OF
MEDICAL LICENSURE & SUPERVISION
P.O. BOX 18256, OKLAHOMA CITY, OK 73154-0256
(405) 962-1400 e-mail: licensing@okmedicalboard.org

VERIFICATION OF SUPERVISION – INDIVIDUAL

PLEASE SELECT: DIRECT □ OR GENERAL □ SUPERVISION

□ADDITIONAL POSITION (keep supervisors on file) □SUPERVISOR CHANGE (delete supervisors currently on file)

NAME OF LICENSEE (PTA) OR APPLICANT (PT OR PTA): _____

License/Application No. _____

Mailing address: _____

_____

Name of Supervisor_____ _____License No. _____

Name of Practice Setting:_____
Address _____
City State Zip _____
Phone: (_____)_____

****NOTE: You will need an additional supervision form for each practice setting with a different supervisor**

THE ABOVE NAMED APPLICANT WILL BEGIN PRACTICE UNDER MY SUPERVISION ON __/__/____

List other Physical Therapist Assistants who I am currently supervising:

Name:_____License Number:_____

Name:_____License Number:_____

By my signature below, I indicate that I fully comprehend the responsibilities discharged to me in the supervision of _____ as a licensed Physical Therapist Assistant or Physical Therapist/Physical Therapist Assistant applicant in the State of Oklahoma according to Title 59 O.S., Section 887.1 – 887.18, Subchapter 7, 435:20-7-1 of the Physical Therapy Practice Act. We agree to abide by the rules of the Board of Medical Licensure and Supervision. I understand that failure to provide responsible supervision may result in disciplinary action against my physical therapy license.

_____

Signature of Supervisor OK License Number Date Signed

_____

Signature of Applicant OK License Number Date Signed