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