FORM #5 (TRS)

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

VERIFICATION OF SUPERVISION

(Please print or type)

NAME OF APPLICANT: _____

Mailing Address: _____

NAME OF SUPERVISOR: _____License Number: TRS_____

NAME OF PRACTICE SETTING (HOSPITAL, CLINIC ETC.) _____

ADDRESS: _____

_____
CITY STATE ZIP

PRACTICE TELEPHONE NUMBER: (_____)_____

THE ABOVE NAMED APPLICANT WILL BEGIN PRACTICE UNDER MY SUPERVISION ON _____/_____/_____.

_____ _____
Signature of Applicant Signature of Supervisor

Sworn to before me this date: _____

(SEAL) _____
Notary Public

Commission Number:_____ My commission expires: _____

NOTE TO SUPERVISOR: Please notify the Board office when your supervision of this individual ceases.