

**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
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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.