Form 2 (MD)

Oklahoma State Board of Medical Licensure and Supervision
101 NE 51st Street Oklahoma City, OK 73105 ~ (405) 962-1470

Email form to: Licensing@okmedicalboard.org
This form must be completed and sent directly to the Board by the training institution

Verification of Graduate Medical Education

Applicant's Name ______________________________

Institution: ______________________ City/State ______________________

Training Level: (e.g. 1, 2, 3, etc.) ____ **Specialty/Subspecialty** ______________ **From:** __/__/__ **To:** __/__/__

☐ **Internship** ☐ **Residency** ☐ **Chief Residency** ☐ **Fellowship** ☐ **Research** **Successfully Completed?** ☐ **YES** ☐ **NO** ☐ **IN PROGRESS**

Accredited By: ☐ **ACGME** ☐ **LCGME** ☐ **RSC** ☐ **CFPC** ☐ **RCPSC** ☐ **None of these**

Training Level: (e.g. 1, 2, 3, etc.) ____ **Specialty/Subspecialty** ______________ **From:** __/__/__ **To:** __/__/__

☐ **Internship** ☐ **Residency** ☐ **Chief Residency** ☐ **Fellowship** ☐ **Research** **Successfully Completed?** ☐ **YES** ☐ **NO** ☐ **IN PROGRESS**

Accredited By: ☐ **ACGME** ☐ **LCGME** ☐ **RSC** ☐ **CFPC** ☐ **RCPSC** ☐ **None of these**

Training Level: (e.g. 1, 2, 3, etc.) ____ **Specialty/Subspecialty** ______________ **From:** __/__/__ **To:** __/__/__

☐ **Internship** ☐ **Residency** ☐ **Chief Residency** ☐ **Fellowship** ☐ **Research** **Successfully Completed?** ☐ **YES** ☐ **NO** ☐ **IN PROGRESS**

Accredited By: ☐ **ACGME** ☐ **LCGME** ☐ **RSC** ☐ **CFPC** ☐ **RCPSC** ☐ **None of these**

Training Level: (e.g. 1, 2, 3, etc.) ____ **Specialty/Subspecialty** ______________ **From:** __/__/__ **To:** __/__/__

☐ **Internship** ☐ **Residency** ☐ **Chief Residency** ☐ **Fellowship** ☐ **Research** **Successfully Completed?** ☐ **YES** ☐ **NO** ☐ **IN PROGRESS**

Accredited By: ☐ **ACGME** ☐ **LCGME** ☐ **RSC** ☐ **CFPC** ☐ **RCPSC** ☐ **None of these**

1.	Did this individual ever take a leave of absence or break from his/her training?	☐ **YES**	☐ **NO**
2.	Was this individual ever placed on probation?	☐ **YES**	☐ **NO**
3.	Was this individual ever disciplined or placed under investigation?	☐ **YES**	☐ **NO**
4.	Were there any negative reports for behavioral reasons ever filed by instructors?	☐ **YES**	☐ **NO**
5.	Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason?	☐ **YES**	☐ **NO**

Please attach separate document for "YES" response(s) from above

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature of the program director (M.D./D.O. only)

Name: ______________________ **Signature** ______________________

Title of Signatory: ______________________ **Signature Date** ______________________

Phone: ____________ **Fax:** ____________ **E-Mail:** ______________________

Revised 03/2024