FORM #5 (Allied)

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

VERIFICATION OF SUPERVISION

_____**Initial Position** _____**Additional Position** _____**Change of Position**

(Please print or type)

NAME OF APPLICANT: _____

License Number:_____

Mailing Address:_____

NAME OF SUPERVISOR: _____

Profession: _____ **License Number:** _____

NAME OF PRACTICE SETTING (HOSPITAL, CLINIC ETC.) AND ADDRESS (Street, 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.

SEE THE STATUTES/ADMINISTRATIVE CODE APPLICABLE TO YOUR SPECIFIC PROFESSION TO DETERMINE THE DEFINITION FOR THE LEVEL OF SUPERVISION REQUIRED.

THE LETTER SIGNED BY THE BOARD SECRETARY AUTHORIZING PRACTICE TO BEGIN WILL STATE THE LEVEL OF SUPERVISION REQUIRED UNTIL A LICENSE IS GRANTED.

DATE: _____ SUPERVISOR: _____

IN MY ABSENCE, SUPERVISION WILL BE PROVIDED BY:

NAME	LICENSE #	SIGNATURE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____