Form 2 (PD)

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 by the program director and sent directly from the program director.

Supervised Practice Program
STATEMENT FOR LICENSURE PURPOSES ONLY

Graduate Being Verified:

_____

First Name **Last Name** **Middle Name**

Our records indicate that the above-named applicant has satisfactorily completed a supervised practice program accredited by the Accreditation Council for Education in Nutrition and Dietetics (ACEND).

Supervised Practice Program Completed _____
Date Format: MM/DD/YYYY

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct.

_____ _____
Name of Institution **Original Signature of Program Director**

_____ _____
Address **Printed Name of Program Director**

_____ _____
City/State/Zip **Title/Department**

Date Form Signed by Program Director _____