

# OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

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## APPLICATION FOR TEMPORARY LICENSURE UNDER

<https://www.sos.ok.gov/documents/executive/1951.pdf>

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**Do not mail or Fax this form.  
For faster processing completed form must be scanned  
and emailed to:**

**[licensing@okmedicalboard.org](mailto:licensing@okmedicalboard.org)**

**Put in the Subject line of the email:**

***" COVID-19 Temporary License Application"***

**This Temporary License is limited to allow your service to  
Oklahomans in need during the Health Emergency due to  
COVID-19 (Novel Coronavirus)**

**Questions?**

**Call: 405-962-1400 – option 1**

**or**

**Email: [licensing@okmedicalboard.org](mailto:licensing@okmedicalboard.org)**

**OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION**  
**101 NE 51<sup>st</sup> St**  
**OKLAHOMA CITY, OK 73105**

**APPLICATION FOR TEMPORARY LICENSURE UNDER**  
**EXECUTIVE ORDER 2020-07**

**Who are eligible?** Medical Doctors (MD), Anesthesiologist Assistants, Athletic Trainers, Licensed Dietitians, Electrologists, Music Therapists, Occupational Therapists & Assistants, Orthotists & Prosthetists, Pedorthists, Physical Therapists & Assistants, Physician Assistants, Radiologist Assistants, Respiratory Care Practitioners, and Therapeutic Recreation Specialists.

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**OTHER ELIGIBILITY REQUIREMENTS and Important Information:**

- a) Hold a license, certificate, or other permit issued by any 50 states, the District of Columbia, US Virgin Islands, Puerto Rico, and Guam.
- b) License must be in good standing (Active and not currently under disciplinary action or restrictions)
- c) How long is the Temporary License good for? Ninety (90) days from issue date or 14 days following the withdrawal or termination of the Executive order.

PRINT OR TYPE ANSWERS TO **ALL QUESTIONS** ON THIS FORM.  
IF NOT APPLICABLE, MUST PUT N/A.

**(1)**

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LAST NAME: _____	MAILING ADDRESS: _____
FIRST NAME: _____	STREET/P.O. BOX: _____
MIDDLE NAME: _____	CITY: _____
SUFFIX: _____ SSN: _____	STATE _____ ZIP: _____

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LIST ALL OTHER NAMES USED (Use additional paper as needed) \_\_\_\_\_

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DATE AND PLACE OF BIRTH:

\_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ COUNTRY \_\_\_\_\_  
Mo. Day Yr.

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(2)

EMERGENCY OR CRITICAL MEDICAL SERVICE LOCATION IN OKLAHOMA:

MEDICAL OR FEDERAL FACILITY \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE NUMBERS: (a) \_\_\_\_\_ (work/mobile) (b) \_\_\_\_\_ (work/mobile)

**Email:** \_\_\_\_\_

LICENSURE - LIST STATES OR TERRITORIES OF THE UNITED STATES IN WHICH YOU ARE LICENSED TO PRACTICE MEDICINE OR SURGERY

(1) LICENSE #: \_\_\_\_\_ TYPE: \_\_\_\_\_ DATE ISSUED: \_\_\_\_\_ STATE \_\_\_\_\_

(2) LICENSE #: \_\_\_\_\_ TYPE: \_\_\_\_\_ DATE ISSUED: \_\_\_\_\_ STATE \_\_\_\_\_

(3) LICENSE #: \_\_\_\_\_ TYPE: \_\_\_\_\_ DATE ISSUED: \_\_\_\_\_ STATE \_\_\_\_\_

I \_\_\_\_\_ ATTEST THAT THE INFORMATION PROVIDED IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**DO NOT WRITE BELOW THIS LINE - FOR OFFICE USE ONLY**

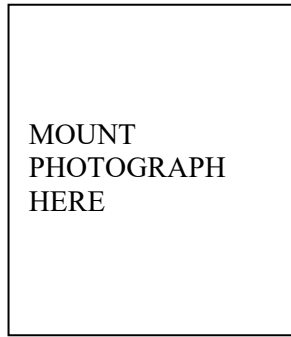
APPLICATION RECEIVED: \_\_\_\_\_

COMMENTS: \_\_\_\_\_

\_\_\_\_\_  
Board Secretary

\_\_\_\_\_  
Approval Date

**PHOTOGRAPH**



THIS PHOTOGRAPH, TAKEN  
WITHIN THE PAST TWELVE  
MONTHS, IS A CORRECT  
LIKENESS OF

MYSELF.

\_\_\_\_\_  
APPLICANT'S SIGNATURE

1. Have you ever had disciplinary action taken against a license, certificate, or permit; any professional or occupational license, recognition, or certificate; and/or any application for a professional or occupational license, recognition or certificate in any state, territory?

Yes No

2. Is there currently any investigation of your license, recognition, or certificate; and/or any professional or occupational license, recognition, or certificate; and/or any application for a license and/or professional or occupational license, recognition, or certificate in any state, territory?

Yes No

**AFFIDAVIT**

By checking this box, I declare and affirm that the statements made in this application are true, complete and correct. I understand that any false or misleading information may be cause for denial or loss of this temporary license.

I, \_\_\_\_\_, hereby certify under oath that I am the person named in the application to render emergency medical treatment or briefly provide critical medical service under ***Executive Order 2020-07 dated 3/17/2020*** in the State of Oklahoma, that all statements I have made herein are true; that the photograph is a true resemblance of me and was made within the last 12 months; that in consideration of the approval for me to render emergency medical treatment or briefly provide critical medical service under the Executive Order. I hereby pledge that I shall abstain from deceptive or fraudulent methods of practice, from immoral, unprofessional and unethical conduct; I shall abstain from professional association with, and shall not act as a shield for, an unlicensed practitioner or other person.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present) and all government agencies (local, state, federal or foreign) to release to the Oklahoma State Board of Medical Licensure and Supervision or its successors any information, files or records requested by that Board in connection with this application. I further authorize the Oklahoma State Board of Medical Licensure and Supervision or its successors to release to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure or licensure renewal.

\_\_\_\_\_  
APPLICANT'S SIGNATURE