OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

APPLICATION FOR TEMPORARY LICENSURE UNDER

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

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

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION
101 NE 51st 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.

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)

LAST NAME:_____ | MAILING ADDRESS:_____

FIRST NAME:_____ | STREET/P.O. BOX: _____

MIDDLE NAME: _____ | CITY: _____

SUFFIX: __ | STATE_____ZIP:_____

SSN:_____

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

DATE AND PLACE OF BIRTH:

_____ CITY_____STATE_____COUNTRY_____
Mo. Day Yr.

(2)

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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

MOUNT PHOTOGRAPH HERE

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