OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION
101 NE 51st STREET
OKLAHOMA CITY OK 73105
Phone: (405) 962-1400 Fax: (405) 962-1440 email: Licensing@okmedicalboard.org

FORM 5 - VERIFICATION OF CURRENT POST-GRADUATE TRAINING

This form must be completed and mailed directly to the Board by the training institution.

NAME OF APPLICANT _____
(type or print)

PROGRAM SPECIALTY--INDICATE ONE (OR TRANSITIONAL)

_____

POST-GRADUATE YEAR LEVEL (circle one) 1 2 3 4 5 6
NAME OF PROGRAM DIRECTOR: _____
NAME OF INSTITUTION SPONSORING PROGRAM_____
_____
(city) (state)
DATE ENTERED: ___/___ /___ DATE EXPECTED TO COMPLETE: ___/___ /___
mo day yr mo day yr
TYPE OF PROGRAM (check one):
ACGME APPROVED RESIDENCY:_____ FELLOWSHIP:_____ INTERNSHIP:_____
NON-APPROVED RESIDENCY:_____ CLERKSHIP:_____ OTHER:_____
If "OTHER", give brief explanation: _____

I, the applicant, do hereby swear or affirm that it is my intention to complete this program by the stated date. Any unforeseen developments that prevent my completion of this program will be reported immediately to the Oklahoma State Board of Medical Licensure and Supervision in writing.

_____
(Print or type name of applicant)

_____
(Signature of applicant)

To my knowledge this applicant has performed satisfactorily in this program to date. Failure to continue satisfactory performance will be reported immediately to the Oklahoma State Board of Medical Licensure and Supervision.

_____
(Print or type name of program director)

INSTITUTION
SEAL

_____
(Original signature of program director)

I have information that should be reviewed by the licensing agency in its deliberations leading to licensure.

_____
(Print or type name of program director)

INSTITUTION
SEAL

_____
(Original signature of program director)