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)

(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)

(Original signature of program director)

MD FORM 5 12/12/2016