OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION P.O. BOX 18256 OKLAHOMA CITY, OK 73154-0256

APPLICATION FOR SPECIAL VOLUNTEER MEDICAL LICENSE

	MAILING ADDRESS:				
FIRST NAME:	STREET / P.O. BOX:				
MIDDLE NAME:	CITY:				
SOC. SEC. SUFFIX: NUMBER:	STATE: ZIP:				
 EGNN'RI QPG'aaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaa	aaaaaa '''''GO C KN aaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaa				
LICENSURE					
LIST ALL JURISDICTIONS, INCLUDING OKLAHOWERE PREVIOUSLY LICENSED:	MA (IF APPLICABLE), IN WHICH YOU ARE LICENSED OR IN WHICH				
PHOTOGRAPH MOUNT PHOTOGRAPH HERE IMPORTANT: AFFIX NOTARY SEAL PARTIALLY ON THE PHOTO AND	THIS PHOTOGRAPH, TAKEN WITHIN THE PAST TWELVE MONTHS, IS A CORRECT LIKENESS OF MYSELF.				
PARTIALLY ON THE APPLICATION	APPLICANT SIGNATURE				
NOTARY SIGNATURE					
COMMISSION NUMBER:	MY COMMISSION EXPIRES:				

MEDICAL SCHOOL:				CITY:	CITY:			
MO/YR ENTERED:		MO/YR DEPAR	TED:/	_ STATE:_	COUNTR	Y:		
	ACCOUN	T FOR A	LL DATES IN CHRO	INCE MEDICAL SCHOO DNOLOGICAL ORDER (LIEU OF COMPLETING	INCLUDE MONTH AND	YEAR)		
FROM MO/YR	TO MO/YR	CITY	COUNTRY OR STATE		ACTICE SETTING LO PRAC., ETC.)		ALTY OR ITY	
ARE YOU FULLY RETIRED FROM THE PRACTICE OF MEDICINE?						YES	NO	
HAVE YOU EVER SURRENDERED A LICENSE OR HAD A LICENSE REVOKED?						YES	NO	
HAS ANY DISCIPLINARY ACTION BEEN TAKEN ON ANY LICENSE?						YES	NO	
HAVE YOU BEEN REQUESTED TO APPEAR BEFORE A LICENSING OR DI					SCIPLINARY AGENCY?	YES	NO	
submitted in attempts to	and with deceive or	the app fraudul	lication is, to th ently portray in	e best of my know formation containe	ns. I swear or affirm ledge, true and factu d herein may result esult in subsequent re	al. I under in cancella	rstand that tion of my	
Signature of	Applicant				Date		_	
Name of App	olicant (type	or print)	1					

Please return your application to:

OSBMLS PO Box 18256 or Oklahoma City, OK 73154-0256 OSBMLS 101 NE 51st Street Oklahoma City, OK 73105