

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

APPLICATION FOR SPECIAL VOLUNTEER MEDICAL LICENSE

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

=====

LAST NAME: _____ MAILING ADDRESS: _____
FIRST NAME: _____ STREET / P.O. BOX: _____
MIDDLE NAME: _____ CITY: _____
SUFFIX: _____ SOC. SEC. NUMBER: _____ STATE: _____ ZIP: _____
"EGNN'RJ QP G"aaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaa""GO CK"aaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaa"

LICENSURE

LIST ALL JURISDICTIONS, INCLUDING OKLAHOMA (IF APPLICABLE), IN WHICH YOU ARE LICENSED OR IN WHICH YOU WERE PREVIOUSLY LICENSED:

PHOTOGRAPH

MOUNT PHOTOGRAPH HERE
IMPORTANT: AFFIX NOTARY SEAL
PARTIALLY ON THE PHOTO AND
PARTIALLY ON THE APPLICATION

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

APPLICANT SIGNATURE

NOTARY SIGNATURE

COMMISSION NUMBER: _____ MY COMMISSION EXPIRES: _____

DO NOT WRITE BELOW THIS LINE - FOR OFFICE USE ONLY

APPLICATION RECEIVED _____ DATE APPROVED _____

COMMENTS: _____

