Oklahoma State Board of Medical Licensure and Supervision
Board Secretary Approval Request

Date: _____

License Type _____ **Number** _____ **Name**_____

Requested Change:

☐ **Employment Information**

Type of change: New Employment ☐ Change of Employment ☐ Additional Employment ☐

Practice Address: _____

Employment Contact Name: _____

Practice Phone: _____ Hours Requested _____

Fill out Employment Statement of Work Page

☐ **Continuing Education**

Course Title	Date	Hours	Remarks

Community Service

Name of Organization/ Description of Service hours	Date	Hours	Remarks

☐ **Therapy**

Name of Organization/Description	Date	Hours	Remarks

☐ **Other**

Name of Organization/Description	Date	Hours	Remarks

Board Secretary Approves _____ Disapproves _____

Board Secretary Comments: _____

Signature _____ Date_____

PO Box 18256
Oklahoma City, OK 73154
Fax (405) 962-1440

Oklahoma State Board of Medical Licensure and Supervision
Board Secretary Approval Request
Employment Statement of Work

Job Duties

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