

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION  
101 NE 51<sup>st</sup> STREET  
OKLAHOMA CITY, OK 73105  
(405) 962-1400

**APPLICATION FOR MODIFICATION**

This form is to be completed if you would like your name changed on your license. If you have **not** been licensed yet, please stop and contact the number above.

**A copy of official document showing the change in name must accompany this application form (i.e., marriage license, divorce decree, etc.)**

**PLEASE MAIL YOUR COMPLETED APPLICATION FORM, FEE AND REQUIRED DOCUMENTS TO THE ADDRESS ABOVE.**

- |  |   |
|--|---|
| <input type="checkbox"/> Anesthesiologist Assistant (\$60)     | <input type="checkbox"/> Orthotist/Prosthetist Assistant (\$30)   |
| <input type="checkbox"/> Athletic Trainer (\$30)               | <input type="checkbox"/> Orthotist/Prosthetist Technician (\$30)  |
| <input type="checkbox"/> Apprentice Athletic Trainer (\$20)    | <input type="checkbox"/> Podiatrist (\$30)                        |
| <input type="checkbox"/> Dietician – Licensed (\$30)           | <input type="checkbox"/> Physician Assistant (\$30)               |
| <input type="checkbox"/> Dietician – Provisional (30)          | <input type="checkbox"/> Physical Therapist (\$60)                |
| <input type="checkbox"/> Electrologist (\$30)                  | <input type="checkbox"/> Physical Therapy Assistant (\$30)        |
| <input type="checkbox"/> Medical Doctor (\$60)                 | <input type="checkbox"/> Radiology Assistant (\$60)               |
| <input type="checkbox"/> Occupational Therapist (\$30)         | <input type="checkbox"/> Respiratory Care Practitioner (\$30)     |
| <input type="checkbox"/> Occupational Therapy Assistant (\$30) | <input type="checkbox"/> Respiratory Care – Provisional (\$25)    |
| <input type="checkbox"/> Orthotist/Prosthetist (\$30)          | <input type="checkbox"/> Therapeutic Recreation Specialist (\$30) |

Enter your name as it is shown on your original license \_\_\_\_\_  
Last First Middle

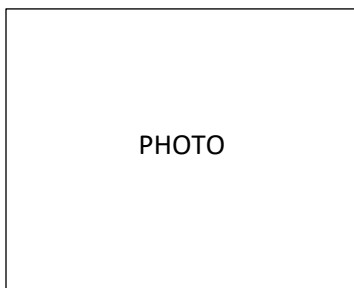
Mailing Address \_\_\_\_\_  
Street City State Zip

Practice Address \_\_\_\_\_  
Street City State Zip

How would you like your name to appear on your license? \_\_\_\_\_  
Last First Middle

What is your license number? \_\_\_\_\_

Photograph must be mounted in space provided and **must** have been taken in the past twelve (12) months. Notary seal must be placed to the bottom of the photo.



Applicant's Signature \_\_\_\_\_

Notary Public Signature \_\_\_\_\_

Commission Number \_\_\_\_\_ Expires \_\_\_\_\_