

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION
101 NE 51ST STREET, OKLAHOMA CITY, OK 73105 (405) 962-1400

VERIFICATION OF EDUCATION

AN EDUCATOR OF THE INSTITUTION FROM WHICH YOU OBTAINED YOUR PROFESSIONAL ACADEMIC DEGREE MUST COMPLETE THIS FORM. THE SEAL OF THE INSTITUTION MUST BE IMPRESSED ON THIS FORM, OR THE STATEMENT AT THE BOTTOM OF THIS FORM MUST BE SIGNED BY THE AUTHOR OF THIS FORM AND THE SIGNATURE NOTORIZED. ALL SIGNATURES MUST BE ORIGINAL.

I, _____, DO HEREBY CERTIFY THAT THE APPLICANT,
Name of educator

_____ ATTENDED _____
Name of applicant Name of institution

LOCATED IN _____, _____, FROM ____ / ____ / ____ TO ____ / ____ / ____
City State mo. day year mo. day year

AND WAS AWARDED THE DEGREE: _____.

_____.

RECORDS OF THIS INSTITUTION INDICATE THAT WHILE ENROLLED THE APPLICANT WAS ____ WAS NOT ____ THE SUBJECT OF DISCIPLINARY ACTION (If applicant was the subject of disciplinary action, please explain on a separate sheet of paper.)

Name of educator - please type or print

Original Signature

Title

Date

(SEAL)

This institution has no seal _____
Signature of educator

Sworn to before me on _____ Commission Number: _____ My commission expires: _____
Date Date

(SEAL)

Notary Signature