

PROTECTIVE
HEALTH
SERVICES

Oklahoma State Department of Health
Protective Health Services
Consumer Protection Division
PO BOX 268815
Oklahoma City, OK 73126-8815
Telephone: (405) 271-5243
FAX: (405)271-3458

FOR OFFICE USE
Date: _____
Approved: _____

NEWLY TRAINED MEDICAL MICROPIGMENTATION APPLICATION

PRINT OR TYPE

Name: _____ Social Security Number _____
Last First Middle

If you ever have been known, by any other name, please list these names: _____

If change was made by court order, enclose herein a Certified Copy of such order.

If married woman, give maiden name _____

Mailing address: _____

Telephone () () () City State Zip
Home Work Mobile/Cell DOB: / / Sex: M F
AGE _____

CERTIFICATION REQUIREMENTS

An individual shall be eligible to apply for a certificate to practice medical micropigmentation by satisfying all of the following criteria. Applicant shall:

- (1) provide his/her high-school diploma or its equivalent and high school phone # () _____;
- (2) be at least twenty-one years of age;
- (3) provide a notarized copy of his/her certificate of birth;
- (4) provide a notarized copy of his/her driver's license or other similar photo identification;
- (5) provide a notarized copy of his/her credentials and professional resume that documents years of practice and number of procedures (if applicable);
- (6) provide proof of successful completion of an OSDH-approved medical micropigmentation training and testing program; and
- (7) pass OSBI background check.

CITIZENSHIP/IMMIGRATION STATUS:

Federal Law limits the issuance of professional licenses, registrations and limited permits to United States citizens or qualified aliens. To comply with this Federal Law, check the appropriate box below, which indicates your Citizenship/Immigration status.

- | | |
|---|--|
| <input type="checkbox"/> A. A United States citizen or national. | <input type="checkbox"/> F. An alien whose deportation is being withheld under Section of 243(h) of the Immigration and Nationality Act. |
| <input type="checkbox"/> B. An alien lawfully admitted for permanent residence in the United State. | <input type="checkbox"/> G. An alien granted conditional entry pursuant to Section 203(a) (7) of the Immigration and Nationality Act as in effect prior to April 1980. |
| <input type="checkbox"/> C. An alien granted asylum under Section 208 of the Immigration and Nationality Act. | <input type="checkbox"/> H. Non Immigrant (Temporarily in U.S.): Please list Visa type or Immigration status or attach a copy of your passport if you are not required to have a Visa to enter the United States:
_____ |
| <input type="checkbox"/> D. A refugee granted asylum under Section 207 of the Immigration and Nationality Act. | |
| <input type="checkbox"/> E. An alien paroled into the United States under Section 212(d)(5) of the Immigration and Nationality Act for a period of at least 1 year. | |

If you check any of the boxes from B-H, enter your alien registration number or control number issued by the Immigration and Naturalization Service in this space _____
INS number

QUESTIONS ABOUT YOUR IMMIGRATION STATUS AND WHETHER OR NOT IT IS A QUALIFYING STATUS, UNDER FEDERAL LAW SHOULD BE DIRECTED TO THE IMMIGRATION AND NATURALIZATION SERVICE (INS) AT: 1-800-375-5283.

CONTINUED ON BACK

SUPERVISING PHYSICIAN INFORMATION

Supervising Physician's Name: _____

Office Name of Supervising Physician: _____

Supervising Physician's Address: _____

City State Zip

Telephone: () Fax: _____

Have you ever been convicted of or pled guilty or nolo contendere to a felony or a misdemeanor involving moral turpitude in any federal, state, territory or District of Columbia court? Yes_____ No_____

Have you ever had health related license, certificate or permit suspended, revoked or not renewed or had any other disciplinary action taken, or had an application for a health related license, certificate, or permit refused by a federal, state, territory, or District of Columbia regulatory authority? Yes _____ No_____

List residences where you have lived for the past five years, but not more than two residences.

From: To:

Street Address City State Mo.& Yr Mo.& Yr.

CERTIFICATION FEES

New application for certification is **\$515.00**. Renewal of certification is **\$100.00**. Reinstatement of certification if the renewal of the certification is 30 days or more after the expiration date is **\$375.00**. Replacement of a certificate is **\$125.00**.

I certify that the information given on this application and the documentation provided is true and correct.

_____/_____/_____
Date

Applicant's Signature

DO NOT SEND CASH! SEND CHECK OR MONEY ORDER ONLY