



**2019 RENEWAL APPLICATION
FOR
FUNERAL DIRECTOR AND/OR EMBALMERS LICENSE**

Date _____

remit to:

State of Oklahoma

Oklahoma Funeral Board
3700 N. Classen - Suite 175
Oklahoma City, OK 73118

Application is hereby made for a Funeral Directors and/or a Embalmers License subject to the laws and rules applicable, and the following information is provided as the basis for the issuance of such license. Please enclose a check or money order. Write your license numbers on the memo part of the check. Return this form to the Board.

Reason for Application: Renewal Update Do Not Wish To Renew

(Add corrections to any missing or incorrect information)

FullName:

correction: _____

ADDRESS:

correction: _____

PHONE:

Current Email Address:

correction: _____

Place Of Employment:

correction: _____

License Number	Renewal Fee
Funeral Directors's License	\$75.00
Embalmer's License	\$75.00
Total Due:	\$150.00

*** MUST BE POST MARKED BY THE U.S POST OFFICE BY DECEMBER 31, FEES DOUBLE JANUARY 1st**

*** PLEASE ALLOW A 4 WEEK TIME PERIOD BEFORE YOU RECEIVE YOUR RECEIPT AND WALLET CARD WHILE WE AUDIT THE CONTINUING EDUCATION INFORMATION**

*

Funeral Director and/or Embalmer Continuing Education

Six hours of continuing education is required for the renewal period, unless you are exempt. Below is the list of exemptions as provided by OAC 235:10-13-12.

1. _____ I am enlisted in military service on active duty.
2. _____ I reside outside the State of Oklahoma
3. _____ I was not engaged in the practice of funeral directing or embalming within the State of Oklahoma during the calendar year 2018.
4. _____ I have a medical disability (You must include a letter from your physician to verify the illness or disability)
5. _____ I am age 65 or older and not the Funeral Director in Charge.
6. _____ I was newly licensed within the past year

**PLEASE DO NOT INCLUDE THE C. E. CERTIFICATES IN THE MAIL;
PLEASE KEEP THEM FOR TWO YEARS FOR AUDITING PURPOSES.**

please indicate the required Ethics credit * please indicate the required physical presence credit

CE Provider's Name	CE Provider's Number	Program Title	Date Attended	Contact Hours
#	#	#	#	#
*	*	*	*	*

By my signature below, I declare under penalty of perjury that all information listed on this renewal form which contains my name, address, place of employment, and continuing education information is true, factual, and complete. I understand that submitting false documents or information to this Board is cause for suspension or revocation of any license granted by this Board.

Signature of Licensee

Date