

**2020 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.

Renewal Update Do Not Wish To Renew

Reason for Application: _____
(Add corrections to any missing or incorrect information)

Full Name: _____

ADDRESS: _____

PHONE: _____ **Current Email Address:** _____

Place Of Employment: _____

<i>License Number</i>	<i>Renewal Fee</i>
Funeral Directors' 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 and I'm not engaged in in the practice of funeral directing or embalming within the State of Oklahoma during the calendar year 2019.
3. _____ I was not engaged in the practice of funeral directing or embalming within the State of Oklahoma during the calendar year 2019.
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 calendar 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