

## SUPERVISING PHYSICIAN'S INFORMATION SHEET

An Oklahoma Certified Micropigmentologist shall provide the Oklahoma State Department of Health, Consumer Protection Division, as specified in OAC 310:234-9.1.1, with the **name, address, phone number and licensure number of EACH of their supervising physicians**; specifically identifying the Oklahoma State Board of Medical Licensure & Supervision, the Oklahoma State Board of Osteopathic Examiners and/or the Oklahoma State Board of Dentistry as the supervising physician's licensing authority. **The Oklahoma Certified Micropigmentologist shall inform the Department of any and all changes thereto.** Please return, in the enclosed envelope to Oklahoma Department of Health, Consumer Protection Division, 1000 NE 10<sup>th</sup> Street, Oklahoma City, OK. 73117-1299

### Physician #1

**Please Print**

Physician Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Licensure #: \_\_\_\_\_ Licensing Board: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Physician #2

**Please Print**

Physician Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Licensure #: \_\_\_\_\_ Licensing Board: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Physician #3

**Please Print**

Physician Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Licensure #: \_\_\_\_\_ Licensing Board: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Physician #4

**Please Print**

Physician Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Licensure #: \_\_\_\_\_ Licensing Board: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_