Oklahoma State Board of Osteopathic Examiners

MEMORANDUM

FROM: Christi Aquino
Director of Licensing

TO: Licensure Applicants

DATE: April 13, 2022

SUBJECT: License Application Documents

Dear Applicant:

This memo includes documents and links to assist you in completing your primary source requirements for licensure. For further questions, please call our office at (405) 528-8625 or send an email to licensing@osboe.ok.gov. **Note: If using FCVS, they will obtain the Post Graduate Training Verification, Medical School Verification, NBOME scores, and Data Bank on your behalf.**

NBOME Transcripts- If you have taken all three parts of the National Board of Osteopathic Examiners sequence, you will use this method of application as your basis for licensure. Please contact the National Board directly at (773) 714-0622 or visit www.nbome.org to request that a transcript of your grades be sent directly to the Oklahoma State Board of Osteopathic Examiners at 4848 North Lincoln Boulevard, Suite 100, Oklahoma City, OK, 73105.

If you have not taken all three parts of the NBOME and have taken the State Board Examination in another state, and received a license in that state, contact us to verify if you are eligible to apply by reciprocity. This is the only reason reciprocity applies.

National Practitioner Data Bank Report- For the National Practitioner Data Bank report, visit https://www.npdb.hrsa.gov/ext/selfquery/SQHome.jsp and start the process for a Self-Query. Follow all instructions given. After your Self-Query has been processed by the NPDB, they will mail or email the report to you. For questions or assistance, call (800) 767-6732 or email help@npdb.hrsa.gov.

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

For State Board Use Only

Postgraduate Training Verification Form (Form #3)

Applicant: DO NOT COMPLETE THIS FORM IF YOU ARE USING FCVS. FCVS verifies this data for you. If you are not using FCVS, complete Section 1 below. Send this form to the current program director of your postgraduate training program. Copy this form for multiple programs.

Program Director or Designated Official: Complete Section 2 of this form. Report internship, residency, and fellowship years on separate pages. Make copies of this form and attach additional pages as needed. Mail completed pages and any other documentation if needed to the board at the address listed in Section 1.

Section 1: Applicant Information

First name_____ Last name_____ Practitioner Type ☐ DO

Middle name_____ Suffix_____ SSN*_____ Birth date (mm/dd/yyyy) _____

Name if different when diploma awarded _____

Name of postgraduate training program _____

**The social security number is to be used for purposes of identification only and may not be used for any other reason.*

Waiver for Release of Information: I request that the program director or a designated official complete Section 2 of this form as outlined above. I authorize the postgraduate training program listed above to provide any and all information pertaining to my training there to the board listed below:

Board name	**Oklahoma State Board of Osteopathic Examiners**
Mailing address	**4848 N. Lincoln Blvd., Suite 100**
City/State/Zip	**Oklahoma City, OK 73105**

Applicant signature_____ Date _____

Section 2: Postgraduate Training Verification

Institution name_____ Affiliated school _____

Institution address w/country _____

Program year(s)_____ Attendance (mm/yyyy) from_____ to_____ Specialty _____

Program type ☐ Internship ☐ Residency ☐ Internship/Residency ☐ Transitional ☐ Fellowship ☐ Fellowship/Research ☐ Other _____

Training status ☐ Completed ☐ In Training ☐ Not Started ☐ Leave of Absence ☐ Withdrawn ☐ Dismissed

Accredited by ☐ ACGME ☐ AOA ☐ APPAP ☐ CFPC ☐ LCGME ☐ RCPSC ☐ RSC ☐ None

The following questions apply to unusual circumstances that occurred during any part of the individual's training. Check the appropriate responses and explain any "Yes" response on a separate sheet of paper. Attach pages as needed.

1.	Did this individual ever take a leave of absence or break from training?	Yes ☐ No ☐
2.	Was this individual ever placed on probation?	Yes ☐ No ☐
3.	Was this individual ever disciplined or placed under investigation?	Yes ☐ No ☐
4.	Were any negative reports for behavioral reasons ever filed by instructors?	Yes ☐ No ☐
5.	Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems, or any other reason?	Yes ☐ No ☐

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature _____

Print name _____

AFFIX INSTITUTIONAL SEAL HERE

(If no seal is available, this form must be notarized.)

Title_____ Date_____

Phone number_____ Fax number _____

Email _____

Please mail this completed form and any other items to the board at the address listed in Section 1. Thank you.

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

For State Board Use Only

Medical or Osteopathic School Verification Form (Form #2)

Applicant: DO NOT COMPLETE THIS FORM IF YOU ARE USING FCVS. FCVS verifies this data for you. If you are not using FCVS, complete Section 1 below. Send this form and a copy of your medical school diploma to the current dean of your medical or osteopathic school. Copy this form for multiple schools.

Dean or Designated Official: Complete Section 2 of this two-page form and certify the enclosed copy of the diploma by placing your school seal on it. Mail the sealed diploma, an official copy of the physician's transcripts, this completed form, and any other documentation needed to the board at the address listed in Section 1. If transcripts are not in English, an original, certified, and official English translation is required.

Section 1: Applicant Information

First name_____ Last name_____ Practitioner Type ☐ DO

Middle name_____ Suffix_____ SSN*_____ Birth date (mm/dd/yyyy) _____

Name if different when diploma awarded _____

Name of school _____

**The social security number is to be used for purposes of identification only and may not be used or any other reason.*

Waiver for Release of Information: I am applying for a license to practice medicine. I authorize the medical/osteopathic school listed above to provide any and all information pertaining to my medical/osteopathic education at that institution to the board at the address listed below. I request that the dean or a designated official complete Section 2 of this form and seal the copy of my diploma (attached) as described in the instructions above, then mail this completed form, the sealed diploma copy, and a copy of my official transcripts to the board listed below at the given address:

Board name	**Oklahoma State Board of Osteopathic Examiners**
Mailing address	**4848 N. Lincoln Blvd., Suite 100**
City/State/Zip	**Oklahoma City, OK 73105**

Applicant signature_____ Date _____

Section 2: Medical or Osteopathic School Verification

School name_____

Complete address w/country _____

School name if different when applicant attended _____

Hours of undergraduate education required for admission_____ Total weeks of education applicant attended _____

Attendance (mm/yyyy) from_____ to_____ Graduation date_____ Degree awarded _____

Unusual Circumstances

The following questions apply to unusual circumstances that occurred during any part of the individual's medical or osteopathic education. Check the appropriate responses and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation attached to this form.

1. Do the official records for this individual reflect interruptions or extensions in his/her medical/osteopathic education? **If yes,** indicate the reasons for each interruption or extension, the dates of each interruption or extension, and whether each interruption or extension was approved or unapproved. Yes ☐ No ☐

☐ Personal or family	From_____ to_____	☐ Approved	☐ Unapproved
☐ Academic remediation	From_____ to_____	☐ Approved	☐ Unapproved
☐ Health	From_____ to_____	☐ Approved	☐ Unapproved
☐ Financial	From_____ to_____	☐ Approved	☐ Unapproved
☐ Participation in a joint degree program	From_____ to_____	☐ Approved	☐ Unapproved
☐ Participation in a non-research special study (e.g., fellowship, intl. experience)	From_____ to_____	☐ Approved	☐ Unapproved
☐ Other _____	From_____ to_____	☐ Approved	☐ Unapproved

2. Do the official records for this individual reflect that he/she was ever placed on academic or disciplinary probation during his/her medical/osteopathic education? **If yes,** indicate below the reasons for each time of probation and the dates of placement on and removal from probation. Also attach documentation or information of each circumstance and outcome. Yes ☐ No ☐

☐ Academic	From_____to_____	☐ Documentation attached
☐ Unprofessional conduct	From_____to_____	☐ Documentation attached
☐ Behavioral reasons	From_____to_____	☐ Documentation attached
☐ Other _____	From_____to_____	☐ Documentation attached

3. Do the official records for this individual reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical/osteopathic school or parent university? **If yes,** explain below and/or attach documentation or information of each circumstance and outcome. Yes ☐ No ☐

4. Do the official records for this individual reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical/osteopathic school or parent university? **If yes,** explain below and/or attach documentation or information of each circumstance and outcome. Yes ☐ No ☐

5. Do the official records for this individual reflect that there were ever any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? **If yes,** explain below and/or attach documentation or information of each circumstance and outcome. Yes ☐ No ☐

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature _____

Print name _____

AFFIX INSTITUTIONAL SEAL HERE

(If no seal is available, this form must be notarized.)

Title_____ Date _____

Phone number_____ Fax number _____

Email _____

Please mail this completed form and any other items to the board at the address listed in Section 1. Thank you.

FINGERPRINTS

NAME OF APPLICANT: _____

TO BE COMPLETED BY A FEDERAL, STATE, OR LOCAL LAW ENFORCEMENT OFFICER.

Make impressions of applicant's fingers and thumb of right hand below:

R. THUMB	R. INDEX	R. MIDDLE	R. RING	R. LITTLE

_____ _____

Printed Name of Officer *Signature of Officer*

_____ _____

Agency Name *Date*

_____

Business Address

_____

City/State/Zip

Note: An official FBI fingerprint card may be substituted for this form.

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

For State Board Use Only

Licensure Verification Form (Form #1)

Applicant: Most boards require verification of each professional license ever held. Refer to the licensure verification resource at http://www.fsmb.org/licensure/uniform-application/ to determine fees and preferred verification method(s) for each state medical and osteopathic verifying board. You may use this form for each board that requires a written request for verification. In Section 1, list the board you are applying to for licensure, using the directory at http://www.fsmb.org/policy/contacts to ensure you list the correct name and address. Mail this completed form and any required fee to the verifying board.

Verifying Board: Unless using electronic verification, complete Section 2 below and mail this form to the board at the address listed in Section 1. Use an additional sheet of paper if needed for explanation(s).

Section 1: Applicant Information

First name_____ Last name_____ Practitioner Type ☐ DO

Middle name_____ Suffix_____ SSN*_____ Birth date (mm/dd/yyyy) _____

**The social security number is to be used for purposes of identification only and may not be used for any other reason.*

Authorization for Verifying Board: I am applying for a license to practice medicine. The board that I am applying to for licensure requires that this form or an otherwise accepted method of verification be completed by all boards through which I hold or have held licenses, whether now current or not. I authorize the licensing agency of the state/province of _____ to provide any and all information pertaining to my license number _____ to the board at the address listed below.

Board name	**Oklahoma State Board of Osteopathic Examiners**
Mailing address	**4848 N. Lincoln Blvd., Suite 100**
City/State/Zip	**Oklahoma City, OK 73105**

Applicant signature_____ Date _____

Section 2: Board Verification of Licensure

Name of issuing board or license entity _____

Name of licensee (last, first, middle, suffix) _____

License type_____ License number_____ Issue date_____ Expiration date _____

1. Is this license current? If not current, please explain: ☐ Yes ☐ No

2. Have formal disciplinary proceedings been initiated against this applicant's license by a disciplinary authority in your state? If yes, please explain on a separate sheet of paper and attach it to this form. ☐ Yes ☐ No ☐ Cannot answer under state law

3. Has the applicant ever been warned, censured, placed on probation, formal consent, reprimand, or in any other manner disciplined, or has the applicant's license ever been revoked, suspended, or, in any other manner, limited by a licensing or disciplinary authority in your state? If yes, please explain on a separate sheet of paper and attach it to this form. ☐ Yes ☐ No ☐ Cannot answer under state law

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature_____

Print name _____

AFFIX INSTITUTIONAL SEAL HERE

(If no seal is available, this form must be notarized.)

Title_____ Date _____

Phone number_____ Fax number _____

Email _____

Please mail this completed form and any other items to the board at the address listed in Section 1. Thank you.

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

For State Board Use Only

Fifth Pathway Verification Form (Form #4 for International students)

Applicant: DO NOT COMPLETE THIS FORM IF YOU ARE USING FCVS. FCVS verifies this data for you. If you are not using FCVS, complete Section 1 below. Send this form to your Fifth Pathway program director.

Program Director or Designated Official: Complete Section 2 of this form. Mail this completed form and any other documentation (if applicable) to the board at the address listed in Section 1.

Section 1: Applicant Information

First name_____ Last name_____ Practitioner Type ☐ DO

Middle name_____ Suffix_____ SSN*_____ Birth date (mm/dd/yyyy) _____

Name if different when certificate awarded _____

Name of medical school _____

**The social security number is to be used for purposes of identification only and may not be used for any other reason.*

Waiver for Release of Information: I request that the program director or a designated official complete Section 2 of this form as outlined above. I authorize the designated official to provide any and all information pertaining to my time there to the board listed below:

Board name	**Oklahoma State Board of Osteopathic Examiners**
Mailing address	**4848 N. Lincoln Blvd., Suite 100**
City/State/Zip	**Oklahoma City, OK 73105**

Applicant signature_____ Date _____

Section 2: Fifth Pathway Verification

Institution name_____ Affiliated school _____

Institution name if different when applicant attended _____

Institution address w/country _____

Type of Clinical Rotation	From	To	Weeks Credit
_____	_____		_____
_____	_____		_____
_____	_____		_____
_____	_____		_____

Completed?

☐ Yes. Attendance was from_____ to_____. Completion date was_____.

☐ No. Withdrawal* date was_____. **If the applicant withdrew or was dismissed, please explain below.*

☐ No. Dismissal* date was_____. **If the applicant withdrew or was dismissed, please explainbelow.*

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature_____

Print name _____

AFFIX INSTITUTIONAL SEAL HERE

(If no seal is available, this form must be notarized.)

Title_____ Date_____

Phone number_____ Fax number _____

Email _____

Please mail this completed form and any other items to the board at the address listed in Section 1. Thank you.

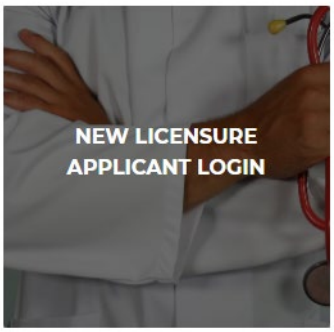
OSBOE Licensure Checklist for 2022-23

www.osboe.ok.gov

Here is a checklist for OSBOE online license application.

1. **Medical School Verification ___ (fill out Section 1 & mail to Med. School)**
2. **PGY 1 Verification ___ (fill out Section 1 & give to Coordinator)**
3. **Residency Verification(PGY 2 – PGY 4) ___ (fill out Section 1)**
4. **Fellowship Verification ___ (fill out Section 1)**
5. **NBOME Scores ___ (request online at www.nbome.org)**
6. **License Fee - $575 ___ (pay with credit card online or send a check)**
7. **National Practitioner Data Bank ___ (YOU can upload your report. Request online at https://iqrs.npdb.hrsa.gov/)**
8. **Birth Certificate/Passport ___ (YOU get copied, notarized, and uploaded)**
9. **Fingerprints ___ (YOU upload online)**
10. **Passport Photo ___ (YOU upload online)**
11. **Licenses from other states (LPN, RN, EMT, etc…)**
12. **If you answer "YES" to any question, provide ALL documentation for this by uploading every document, including your explanation of events.**

Click on this tile on the front page of our website:



Pre-License Application Questions

These are the questions that will be on the online application.

1. Have you ever been rejected for membership by or requested to appear before any medical or osteopathic society?
   If Yes, provide the name and address of the society, dates, and reasons on a separate page. Also, please furnish a separate letter addressed to each applicable society, which authorizes them to release whatever information this Board may require.

2. Have you ever been denied the privilege of taking an examination administered by any licensing board agency?
   If Yes, please provide the name of the examination and the agency's name on a separate sheet of paper.

3. Have you ever been denied a license to practice osteopathic medicine, withdrawn your application, or have had your application tabled?
   If Yes, please provide full details on a separate page. This must include the state(s), date(s), and reason(s).

4. Have you ever been denied staff membership or employment with any licensed hospital, nursing home, clinic, health maintenance organization, or other hospital care facility with an organized medical staff?
   If Yes, provide full details, including addresses, on a separate page. Also, please furnish a separate letter addressed to each applicable institution or organization authorizing them to release whatever information this Board may require.

5. Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, had privileges suspended, been put on probation, or ever been requested to withdraw from any medical school, training facility, medical practice, hospital, nursing home, clinic, health maintenance organization, or other hospital care facility?
   If Yes, provide full details, including addresses, on a separate page. Also, please furnish a separate letter addressed to each applicable institution or organization authorizing them to release whatever information this Board may require.

6. Have you ever been requested to resign, withdraw, or otherwise terminate your position with a medical school, training program, medical practice, medical partnership, hospital, professional association, corporation, health maintenance organization, or other medical practice organization, either public or private?
   If Yes, provide full details, including addresses, on a separate page. Also, please furnish a separate letter addressed to each applicable entity authorizing them to release whatever information this Board may require.

7. Have you ever, for any reason, lost Board Certification in any specialty or had your status suspended or tabled?
   If Yes, provide full details on a separate page. Also, please furnish a separate letter addressed to the specialty board authorizing them to release whatever information this Board may require.

8. Has any state or federal licensing authority or disciplinary agency, including but not limited to other state or federal licensure boards, limited, placed on probation or conditions, restricted, suspended, or revoked a license or permit you have held?
   If Yes, give full details on a separate page. This should include the state(s), date(s), and reason(s).

9. Have you ever voluntarily surrendered a license to practice medicine, surrendered in lieu of an investigation or complaint, allowed it to expire or lapse, retired a license while under an investigation or complaint, lost hospital privileges, lost specialty board membership, or permit issued to you by any licensing agency or hospital?
   If Yes, give full details on a separate page. This should include the states, dates, and reasons.

10. Have you ever been requested to appear before any licensing board or disciplinary agency?
    If Yes, give full details on a separate page. This should include the state(s), date(s), and reason(s)

11. Have you ever been formally notified of any investigations, violations, or complaints against you with any licensing board or disciplinary agency?
    If Yes, give full details on a separate page. This should include the state(s), date(s), and reason(s).

12. Do you currently, or within the last two years, have any condition or diagnosis for any mental or physical illness that would hinder your ability to practice osteopathic medicine?
    If Yes, give full details on a separate page. Also, please provide a separate letter addressed to each physician, therapist, and/or institution authorizing them to release whatever information this Board may require. This letter will be used to verify your information and obtain records concerning your care and treatment.

13. Within the last two years, have you had an interruption in your training or medical practice because of a physical, mental, emotional, or chemical impairment?
    If Yes, provide full details, including information concerning your diagnosis and treatment and date of occurrence, treating physician(s), etc., in a separate notarized statement. Furnish a separate letter addressed to each, authorizing them to release whatever information this Board may require, including your medical records.

14. Have you ever been denied a Drug Enforcement Administration (DEA) certificate or a state bureau of narcotics controlled substances registration certificate, been called before, or warned by any such agency or other lawful authority concerned with controlled substances?
    If Yes, provide full details in a separate notarized statement.

15. Has the Drug Enforcement Administration (DEA) or any state bureau of narcotics ever limited, placed on probation or conditions, restricted, suspended, or revoked a license or permit you have held?
    If Yes, provide full details, including dates, in a separate notarized statement.

16. Have you ever surrendered or had disciplinary action taken against your federal or state controlled substances registration?
    If Yes, provide full details, including dates, in a separate notarized statement.

17. Have you ever been arrested, fined, charged with, or convicted of a crime, received a deferred sentence, expungement, entered an Alford plea or nolo contendere, indicted, imprisoned, or placed on probation? All arrests, including all DUI/DWI arrests or convictions, shall be reported here.
    If Yes, give full details of the arrest, dates, places, and disposition in a separate notarized statement, even if the case was expunged. You must also furnish a certified court copy (with seal affixed) of the charge, the judgment, the sentence, and/or dismissal order or other such documents attesting to the disposition. You do not need to include minor traffic and parking violations except those related to DUI, DWI, or a similar charge.

18. Have you ever forfeited collateral for breach or violation of any law, police regulation, or ordinance, been summoned into court as a defendant, or have any lawsuit (other than malpractice) been filed against you?
    If Yes, give full details in a separate notarized statement. You need not include traffic violations such as a speeding ticket where a bond was forfeited except those related to DUI, DWI, or some similar charge. If you have ever been the defendant in any legal action, furnish a certified court copy (with seal affixed) of the original complaint, answer, judgment, settlement, and/or disposition of the case. If it is pending, state and have your attorney provide a letter regarding the case and its current status.

19. Have you ever been denied provider participation in any state Medicaid, federal Medicare program, or third-party payor? **If Yes**, give full details, including dates and the names and addresses of the Medicaid, Medicare program, or any other payor in a separate notarized statement. Furnish a letter addressed to each, authorizing them to release whatever information the Board may require.

20. Have you ever been terminated, sanctioned, penalized, settled, or had to repay monies to any state Medicaid, federal Medicare program, or any third-party payor?
    If Yes, give full details, including dates and the names and addresses of the Medicaid or Medicare program, in a separate notarized statement. Furnish a separate letter, addressed to each, authorizing them to release whatever information this Board may require.

21. Have you ever been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid on your behalf or paid such a claim yourself?
If Yes, provide all information required within the Malpractice Liability Claims section of the Uniform Application.

22. Have you ever been reported to the National Practitioner Data Bank (NPDB)?
If Yes, provide the data bank report and any documents pertaining to the incident, and provide a letter stating what occurred in your own words.

23. Are you currently taking any scheduled prescription medications, including but not limited to all opioids and stimulants or any illegal substances of any kind? Any applicant with a valid Oklahoma Medical Marijuana card is excused from reporting the existence of their Medical Marijuana License on this application.
If Yes, provide the pertinent information regarding the illness, giving rise to the need for the medication, the name of the drug(s), dosage, etc., in a separate notarized statement. This statement should also discuss who prescribes your medication, where you obtain it, etc. Provide a letter addressed to each prescribing physician, pharmacy, and/or other entity, authorizing them to release any information this Board may require.