Dear Applicant:

The Oklahoma State Board of Osteopathic Examiners is pleased that you are interested in achieving licensure in the state of Oklahoma. As you can see from this packet, the process is lengthy. Upon completion, your application will be reviewed for quality assurance by the Board. You may be required to come before the Board for an interview as part of the application process. Please do not assume that licensure is a mere formality or that the granting of a license is automatic. We will not begin working on your application until we have received a completed OSBOE application and the required fee. We look forward to working with you to make your process an easy and smooth experience.

Uniform Application for Physician State Licensure (UA):

The Oklahoma State Board of Osteopathic Examiners utilizes our own modified version of the Uniform Application. Please see the Uniform Application enclosed in this packet. We also require completion of our Pre Licensing Packet (PLP), which was created and approved for use in our application process in 2010. Please type or print in ink. The Board stresses that you must provide full details and dates, complete names, addresses, zip codes and your proposed practice location as required in the application. If you do not, the processing of your application will be delayed.

The Federation Credentials Verification Service (FCVS):

FCVS is a service of the Federation of State Medical Boards (FSMB) and was created to assist in license portability for physicians. The Board does not require the use of FCVS to primary source verify core physician credentials as part of the licensure process. It is recommended if the applicant wishes to be licensed in multiple states. Contact FCVS at 888-ASK-FCVS (888-275-3287) for additional information regarding the service and its fees. If you have previously used their service, call FCVS to designate your credentials to be received by the Oklahoma State Board of Osteopathic Examiners.

Important:

Even if using FCVS, you must still apply for licensure in the State of Oklahoma by submitting our UA, the Oklahoma Pre-Licensing Packet, a licensure application fee of $575.00, and certain other documentation. To ensure that the process goes well, we suggest you follow the enclosed instructions carefully and completely. Should you have questions regarding the application form or process, feel free to contact the Board office for assistance.

Sincerely,

Christi Aquino
Admin. Programs Officer/ Licensure Specialist
OKLAHOMA STATE BOARD OF OSTEOPATHIC EXAMINERS
4848 North Lincoln Boulevard, Suite 100
Oklahoma City, OK 73105
405.528.8625
INSTRUCTIONS FOR COMPLETING YOUR LICENSURE APPLICATION TO THE OKLAHOMA STATE BOARD OF OSTEOPATHIC EXAMINERS

The application contains two (2) parts – the UA (Uniform Application for Physician State Licensure) and the PLP (Oklahoma’s Pre-Licensing Packet). Complete the application as instructed in each section. PLEASE TYPE OR PRINT IN INK. In addition, please note the following:

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 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. This step is referenced in the UA. Note: If using FCVS, they will contact NBOME for you.

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. Note: FLEX and USMLE examinations are not accepted by this Board as a basis for licensure.

Computer-generated photos are not acceptable. We need a 2x2 passport (or similar) photo with a clear white or light background for your application. Complete all physical identifiers in the spaces provided, even if you’ve provided them to FCVS.

The document verifying lawful presence in the United States must be completed and notarized. This is required by Oklahoma State Law and no other document may be substituted for this form.

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. You must mail all of the original report directly to this board. For questions or assistance, call (800) 767-6732 or email help@npdb.hrsa.gov.

ADDITIONAL INFORMATION

Postgraduate training must be at least one (1) year of rotating internship with either the AOA or the ACGME in an accredited or residency program acceptable to the Board.

A. All licenses must be renewed each year prior to July 1st and you must obtain sixteen (16) hours of AOA-approved 1-A or 1-B Continuing Medical Education credit hours each licensure year. You must receive at least one (1) hour of education in pain management, opioid use or addiction. This hour must be attended in-person or via live interactive media which enables attendees to ask live questions with immediate responsive answers and interaction. (Physicians in a residency, fellowship program or active duty military are exempt from all CME requirements) Please be aware that all licenses expire on June 30th of each year. All licensees will be required to renew between May 10th and June 30th, regardless of when the license is issued.

B. You may request a Drug Enforcement Administration (DEA) application after you are licensed and have registered with the Oklahoma Bureau of Narcotics and Dangerous Drugs (OBNDD) Drug Enforcement Administration - (405) 475-7500
Oklahoma Bureau of Narcotics - (405) 521-2885

C. When requesting license verifications from states where you are or have been licensed, request through each participating Board you have been licensed with.
PRE-LICENSING PACKET

FULL NAME OF APPLICANT: ____________________________________________________________

*Name as you want it to appear on your license: __________________________________________

Osteopathic Specialty: ________________________________________________________________

Board Certified: ☐ Yes ☐ No If Yes, by which board? ________________________________________

CURRENT practice activity: ☐ PGY1 ☐ Resident ☐ Fellowship ☐ Private ☐ Other (explain): ______

Proposed location address and type of Oklahoma-based practice if license is granted:
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Contact Telephone Numbers:

Cell: ___________________ Home: ___________________ Other: ___________________

Name of Undergraduate School (Not Medical School): _________________________________

City/State: ___________________ Graduation Year: ___________________

Are you using FCVS to verify your core credentials? FCVS is not a requirement for licensure. FCVS will primary source verify and provide a copy of the osteopathic medical school transcript(s), name change documents(s), and national exam score report. Using this service will expedite your application only if the FCVS was complete prior to submitting your application. YES ☐ NO ☐

ITEMS TO MAIL TO THE BOARD WITH THE PLP (Pre-Licensing Packet):

1. PLP Packet – all 6 pages of this packet
2. Cashier’s Check – $575.00 (Application for Licensure Fee)
3. Notarized Copy of Birth Certificate or Passport
4. UA – Uniform Application for Physician State Licensure

ADDITIONAL ITEM (may be mailed separately):

5. Report from the National Practitioner Data Bank (Results of Self-Query)
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you ever been rejected for membership by, or requested to appear, before any medical or osteopathic society?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
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</tr>
<tr>
<td>2. Have you ever been denied the privilege of taking an examination administered by any licensing agency?</td>
<td></td>
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</tr>
<tr>
<td>If Yes, please provide the name of the examination and the name of the agency on a separate sheet of paper.</td>
<td></td>
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<tr>
<td>3. Have you ever been denied a license to practice osteopathic medicine, withdrawn your application or have had your application tabled?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If Yes, please provide full details on a separate page. This must include the state(s), date(s), and reason(s).</td>
<td></td>
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</tr>
<tr>
<td>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?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
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</tr>
<tr>
<td>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 practice, hospital, nursing home, clinic, health maintenance organization, or other hospital care facility with an organized medical staff, in which you have trained, been a staff member, been an employee, been a partner, or held hospital privileges?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
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</tr>
<tr>
<td>6. Have you ever been requested to resign, withdraw, or otherwise terminate your position with a medical practice, medical partnership, professional association, corporation, health maintenance organization, or other medical practice organization, either public or private?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Have you ever, for any reason, lost Board Certification in any specialty or had your status suspended or tabled?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
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<tr>
<td>8. Has any licensing authority or disciplinary agency limited, probated, restricted, suspended, or revoked a license or permit you have held?</td>
<td></td>
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</tr>
<tr>
<td>If Yes, give full details on a separate page. This should include the state(s), date(s), and reason(s).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Have you ever voluntarily surrendered, allowed to expire, retire a license, lost hospital privileges, lost specialty board membership, or permit issued to you by any licensing agency or hospital?</td>
<td></td>
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<tr>
<td>If Yes, give full details on a separate page. This should include the states, dates, and reasons.</td>
<td></td>
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<tr>
<td>10. Have you ever been requested to appear before any licensing or disciplinary agency?</td>
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<tr>
<td>If Yes, give full details on a separate page. This should include the state(s), date(s), and reason(s).</td>
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</tr>
<tr>
<td>11. Have you ever been notified of any charges or complaints filed against you with any licensing or disciplinary agency?</td>
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</tr>
<tr>
<td>If Yes, give full details on a separate page. This should include the state(s), date(s), and reason(s).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>12. Have you ever been diagnosed or treated for any mental or physical illness that would hinder your ability to practice osteopathic medicine?</td>
<td></td>
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<tr>
<td>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 the information you have given and to obtain records concerning your care and treatment.</td>
<td></td>
<td></td>
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<tr>
<td>13. Have you ever been chemically dependent?</td>
<td></td>
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</tr>
<tr>
<td>If Yes, give full details on a separate page. In addition, please provide a separate letter addressed to each physician, therapist, institution, and support group that provides care and treatment and after care, authorizing them to release whatever information this Board may require. This letter will be used to verify the information you have given and to obtain records concerning your care, treatment, and participation.</td>
<td></td>
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</tr>
<tr>
<td>14. Have you ever interrupted your training because of illness or impairment (physical, mental or chemical)?</td>
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<tr>
<td>If Yes, provide full details including dates and the names and addresses of each training institution on a separate notarized statement. Furnish a separate letter addressed to each institution authorizing them to release whatever information this Board may require.</td>
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<tr>
<td>15. Have you ever been unable to practice osteopathic medicine because of illness or impairment?</td>
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<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Have you ever been denied a Drug Enforcement Administration (DEA) certificate or a state bureau of narcotics controlled substances registration certificate, or been called before, or warned by any such agency or other lawful authority concerned with controlled substances?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If Yes, provide full details in a separate notarized statement.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Has the Drug Enforcement Administration (DEA) or any state bureau of narcotics ever limited, probated, restricted, suspended, or revoked a license or permit you have held?</td>
<td></td>
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<tr>
<td>If Yes, provide full details, including dates, in a separate notarized statement.</td>
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<tr>
<td>18. Have you ever surrendered or had disciplinary action taken against your federal or any state controlled substances registration?</td>
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<tr>
<td>If Yes, provide full details, including dates, in a separate notarized statement.</td>
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<td></td>
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<tr>
<td>19. Have you ever been arrested, fined, charged with, or convicted of a crime, received a deferred sentence, entered an Alford plea or nolo contendere, indicted, imprisoned, or placed on probation?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If Yes, give full details of the arrest, dates, places, and disposition of the case in a separate notarized statement. 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 need not include minor traffic and parking violations except those related to DUI, DWI, or a similar charge.</td>
<td></td>
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</tr>
<tr>
<td>20. Have you ever forfeited collateral for breach or violation of any law, police regulation or ordinance, been summoned into court as a defendant, or has any lawsuit (other than malpractice) been filed against you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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, so state and have your attorney provide a letter regarding the case and its current status.</td>
<td></td>
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</tr>
</tbody>
</table>
### Applicant Name

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<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>21. Have you ever been denied provider participation in any state Medicaid, federal Medicare program, or any third-party payor?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>If Yes</strong>, 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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Have you ever been terminated, sanctioned, penalized, or had to repay monies to any state Medicaid, federal Medicare program or any third party payor?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>If Yes</strong>, 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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Have you ever been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>If Yes</strong>, provide all information required within the Malpractice Liability Claims section of the Uniform Application.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. Are you now taking scheduled prescription medication, marijuana or any illegal substances of any kind?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>If Yes</strong>, 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.</td>
<td></td>
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</tr>
</tbody>
</table>

_I hereby state, under oath, that I authorize an investigation to be made as to my moral character, professional reputation, and fitness for the practice of osteopathic medicine, when, in the opinion of the Oklahoma State Board of Osteopathic Examiners, such an investigation is deemed necessary. I further certify that all statements I have made herein are true and I understand that the fee I submitted is not refundable._

________________________________________
(Applicant’s Signature)

Subscribed and sworn to before me this _________day of ________________________, 20__.  
My commission expires: ________________________  
My commission number: ________________________

________________________________________
(Notary Public Signature & Seal)
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.
AFFIDAVIT VERIFYING LAWFUL PRESENCE IN THE UNITED STATES

Affidavit of

________________________________________
[Applicant’s Name] – Please Print

Option 1 – Verification of Citizenship

☐ I am a United States Citizen.

[Signature of Applicant]

(or)

Option 2 – Affidavit Verifying Qualified Alien Status

☐ I am a qualified alien under the federal Immigration and Naturalization Act, and I am lawfully present in the United States.

[Signature of Applicant]

Notary Required for either Option:

STATE OF __________________________ ) ss:
COUNTY OF ________________________

Subscribed and sworn to, or affirmed, before me this _____ day of ______________, 20____.

by ____________________________________________________

[Applicant]

_____________________________________________________

[Notary Public]

My Commission Number: ______________ expires: ______________________

(Seal)

Instructions for Required Affidavit:

All natural persons fourteen (14) years of age or older and present in the United States, applying for a license, or renewal of an existing license, with the Oklahoma State Board of Osteopathic Examiners are required, by the provisions of 56 O.S. Supp. 2007 § 71, to provide the Board with verification of lawful presence in the United States by executing this Affidavit before a notary public or other officer authorized to notarize affidavits under State law.
UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE
CHECK LIST

After completing the enclosed application, you are responsible for submitting the application along with certain documents. There are two different checklists below; one when you are using the Federation Credentials Verification Service (FCVS) and one when you are not using FCVS. Please use the checklist that applies to you.

<table>
<thead>
<tr>
<th>Requirement</th>
<th>NOT using FCVS to verify credentials</th>
<th>Using FCVS to verify credentials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submit the completed Uniform Application (including pre-licensing packet), fees, and other required documentation to the Board.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Enclose fingerprint form or card when submitting this application to the Board.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Send results of the National Practitioner Data Bank self-query directly to the Board. (This may be mailed separately from the completed application.)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Enclose the completed and notarized “Affidavit and Authorization for Release of Information” form when submitting this application to the Board.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Have the State Licensure Verification form (Form #1) or other form of verification sent to the Board from all states in which you have ever held any healthcare license.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Enclose a notarized copy of your birth certificate or current, valid passport when submitting this application to the Board.</td>
<td>☐</td>
<td>Completed via FCVS</td>
</tr>
<tr>
<td>Enclose supporting documentation of any legal name change when submitting this application to the Board.</td>
<td>☐</td>
<td>Completed via FCVS</td>
</tr>
<tr>
<td>Have the Medical Education Verification form (Form #2) sent to the Board from all medical schools attended. Include a copy of your diploma (must be sealed by your school).</td>
<td>☐</td>
<td>Completed via FCVS</td>
</tr>
<tr>
<td>Have the Medical school transcripts sent to the Board by your medical school(s).</td>
<td>☐</td>
<td>Completed via FCVS</td>
</tr>
<tr>
<td>Have the Postgraduate Training Verification form (Form #3) sent to the Board from all programs you attended.</td>
<td>☐</td>
<td>Completed via FCVS</td>
</tr>
<tr>
<td>Enclose a copy of your postgraduate training certificate(s) when submitting this application to the Board.</td>
<td>☐</td>
<td>Completed via FCVS</td>
</tr>
<tr>
<td>Have the Fifth Pathway form (Form #4) (if applicable) sent to the Board from the medical school and institution. Include a copy of your diploma (must be sealed by your school).</td>
<td>☐</td>
<td>Completed via FCVS</td>
</tr>
<tr>
<td>Have your Examination Transcripts sent to the Board.</td>
<td>☐</td>
<td>Completed via FCVS</td>
</tr>
<tr>
<td>Have a notarized copy of ECFMG Certificate (if applicable) sent to the Board.</td>
<td>☐</td>
<td>Completed via FCVS</td>
</tr>
</tbody>
</table>
Core Uniform Application

Applicant: Complete all fields. Pay special attention to the instructions in teal in each section. Copy blank pages as needed and attach the additional pages of typed or neatly printed information to this application.

When finished, mail with other required materials to the Oklahoma State Board of Osteopathic Examiners, 4848 N. Lincoln Blvd., Suite 100, Oklahoma City, OK 73105.

Personal Information

List your full legal name and each name you have been identified under, including all misspellings and names you did not use. If you need additional space, list the other names on a separate sheet of paper and attach it to this application. Type or print neatly.

- First name ___________________ Last name ___________________ Practitioner Type □ DO
- Middle name ___________________ Suffix ___________________ SSN* ___________________ NPI number** ___________________
- Maiden/other names ___________________ Gender - ___________________ Birth date (mm/dd/yyyy) ___________________
- Birth country ___________________ Birth city ___________________ Birth state/province ___________________

Are you a United States Citizen? □ Yes □ No □ I prefer not to answer USMLE or ECFMG ID ___________________

* Your social security number is required to facilitate reporting to the National Practitioner Data Bank, for accurate identification under federal and state child support enforcement laws, for investigative/enforcement purposes, and as otherwise required by law. List your complete SSN unless stated otherwise in the board's instructions.

** The National Provider Identifier number is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. For more information, visit http://www.cms.hhs.gov/NationalProvIdentStand/.

Contact Information

List an address, phone number, and email for both home and business. Each address must be located in the United States or Canada.

Public Access:

- Practice address ___________________________________________ County:
  - Practice phone number ___________________ Public email ___________________

Private OSBOE use only:

Home address ___________________________________________
- Home phone number ___________________ Private email ___________________

Preferred Mailing Address: □ Home
□ Practice

Medical / Osteopathic School(s)

Complete all fields for your medical and/or osteopathic school(s). If you attended more than two schools, list the additional information on a separate sheet of paper and attach to this application.

1. Start date _______ Medical school name ___________________
   End date _______ Complete address ___________________________________________
   Graduation date ___________________
   Degree earned (select one from the below list)
   □ BM □ DO □ MDMCH □ MBBCH □ BMBS □ DM □ DMCH □ DMMS □ DMS
   □ BMBCH □ DOM □ MBBCH □ MD □ MBCBH □ MDCH □ MDCHM □ MD
   □ MDPHD □ MSMD □ PA □ PHYS □ PS

2. Start date _______ Medical school name ___________________
   End date _______ Complete address ___________________________________________
**Postgraduate Training**

List all postgraduate training programs you have attended in the United States and Canada. Use the categories in the chart below for the applicable fields. If you attended more than five postgraduate training programs, list the additional information on a separate sheet of paper and attach to this application. List all international postgraduate training programs in the Chronology of Activities section.

<table>
<thead>
<tr>
<th>Program Type</th>
<th>Accreditation</th>
<th>Training Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internship</td>
<td>Jr. Registrar</td>
<td>ACGME (Accreditation Council for Graduate Medical Education)</td>
</tr>
<tr>
<td>Categorical</td>
<td>Registrar</td>
<td>AOA (American Osteopathic Association)</td>
</tr>
<tr>
<td>Transitional</td>
<td>Sr. Registrar</td>
<td>APPAP (Associate of Postgraduate Physician Assistant Programs)</td>
</tr>
<tr>
<td>Preliminary</td>
<td>House Officer</td>
<td>CFPC (The College of Family Physicians Canada)</td>
</tr>
<tr>
<td>Rotational</td>
<td>Sr. House Officer</td>
<td>LCGME (Liaison Committee for Graduate Medical Education)</td>
</tr>
<tr>
<td>Residency</td>
<td>Fellowship</td>
<td>RCPCSC (The Royal College of Physicians and Surgeons of Canada)</td>
</tr>
<tr>
<td>Internship/Residency</td>
<td>Research</td>
<td>RSC (Royal Society of Chemistry)</td>
</tr>
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</table>

1. Start date_________ In institution name ____________________________________________
   End date_________ Complete address _______________________________________________
   □ In progress  Training area_________________ Specialty ____________________________
   Program year(s)______ Affiliated school ____________________________________________
   Program type________________ Accreditation _______________ Training status __________
   (use above categories for this line)

2. Start date_________ In institution name ____________________________________________
   End date_________ Complete address _______________________________________________
   □ In progress  Training area_________________ Specialty ____________________________
   Program year(s)______ Affiliated school ____________________________________________
   Program type________________ Accreditation _______________ Training status __________

3. Start date_________ In institution name ____________________________________________
   End date_________ Complete address _______________________________________________
   □ In progress  Training area_________________ Specialty ____________________________
   Program year(s)______ Affiliated school ____________________________________________
   Program type________________ Accreditation _______________ Training status __________

4. Start date_________ In institution name ____________________________________________
   End date_________ Complete address _______________________________________________
   □ In progress  Training area_________________ Specialty ____________________________
   Program year(s)______ Affiliated school ____________________________________________
   Program type________________ Accreditation _______________ Training status __________

5. Start date_________ In institution name ____________________________________________
   End date_________ Complete address _______________________________________________
   □ In progress  Training area_________________ Specialty ____________________________
   Program year(s)______ Affiliated school ____________________________________________
   Program type________________ Accreditation _______________ Training status __________

**ECFMG**

Select the checkbox that applies to you. List your certificate information if applicable.

□ I do not have an ECFMG certificate.
□ I have ECFMG certificate number_________________ issued on _____________.
Fifth Pathway

Select the checkbox that applies to you. List your program information if applicable.

☐ I did not participate in or complete a Fifth Pathway program.
☐ I completed the Fifth Pathway program listed below.

Full school name

Institutions where rotations performed

Institution address

Start date of rotations End date of rotations Certification date

Examination History

List all examinations you have taken. If you are not using FCVS for credentials verification and need to request transcripts for the board, refer to the UA FAQ at http://www.fsmb.org/licensure/uniform-application/faq.

<table>
<thead>
<tr>
<th>Examination</th>
<th>Most recent date taken</th>
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<th>Number of attempts</th>
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<tr>
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<tr>
<td>USMLE Step 2 CS</td>
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<td>USMLE Step 2 CK</td>
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<td>USMLE Step 3</td>
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<td>FLEX Pre-1985</td>
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<td>FLEX Component 1</td>
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<tr>
<td>FLEX Component 2</td>
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<td>SPEX</td>
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<tr>
<td>NBME Part I</td>
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<td>(P) (F)</td>
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</tr>
<tr>
<td>NBME Part II</td>
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<td>(P) (F)</td>
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</tr>
<tr>
<td>NBOME Part III</td>
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<td>(P) (F)</td>
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</tr>
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<td>COMLEX Level 2</td>
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</tr>
<tr>
<td>NBOME-COMLEX Level 1</td>
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<tr>
<td>NBOME-COMLEX Level 2 CE</td>
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<td>NBOME-COMLEX Level 2 PE</td>
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<td>LMCC Part B</td>
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</tr>
<tr>
<td>LMCC Qualifying Exam Part I</td>
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<td>LMCC Qualifying Exam Part II</td>
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</tr>
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<td>(P) (F)</td>
<td></td>
</tr>
<tr>
<td>PA National Certifying Exam</td>
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<td>(P) (F)</td>
<td></td>
</tr>
<tr>
<td>PA National Recertification Exam</td>
<td></td>
<td>(P) (F)</td>
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</tr>
<tr>
<td>State Board</td>
<td></td>
<td>(P) (F)</td>
<td></td>
</tr>
<tr>
<td>State Board</td>
<td></td>
<td>(P) (F)</td>
<td></td>
</tr>
</tbody>
</table>
State Licensure

List all professional licenses you have ever held in the United States or Canada. Use the categories in the chart below for the applicable fields. Refer to the state board directory at [http://www.fsmb.org/policy/contacts](http://www.fsmb.org/policy/contacts) to ensure you use the correct name of each state board. If you have more than nine licenses to report, copy this page as needed, then list the information and attach to this application.

<table>
<thead>
<tr>
<th>Practitioner License Type</th>
<th>License Type</th>
<th>License Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD – Doctor of Medicine</td>
<td>Administrative</td>
<td>Active</td>
</tr>
<tr>
<td>DO – Doctor of Osteopathic Medicine</td>
<td>Full</td>
<td>Applicant</td>
</tr>
<tr>
<td>DPM – Doctor of Podiatric Medicine</td>
<td>Limited</td>
<td>Cancelled</td>
</tr>
<tr>
<td>DC – Doctor of Chiropractic</td>
<td>Military</td>
<td>Closed</td>
</tr>
<tr>
<td>DDS – Doctor of Dental Surgery</td>
<td>Retired</td>
<td>Conditional</td>
</tr>
<tr>
<td>DMD – Doctor of Dental Medicine</td>
<td>Special</td>
<td>Deceased</td>
</tr>
<tr>
<td>EMT – Emergency Medical Technician</td>
<td>Supervising</td>
<td>Deleted</td>
</tr>
<tr>
<td>LPN – Licensed Practical Nurse</td>
<td>Teaching</td>
<td>Delinquent</td>
</tr>
<tr>
<td>PA – Physician Assistant</td>
<td>Temporary</td>
<td>Disabled</td>
</tr>
<tr>
<td>Psy.D. – Doctor of Psychology</td>
<td>Training</td>
<td>Exempt</td>
</tr>
<tr>
<td>RN – Registered Nurse</td>
<td>Volunteer</td>
<td>Expired</td>
</tr>
</tbody>
</table>

1. State or province ___________ Licensure board ___________
   License number ___________ Issue date ___________ Expiration date ___________
   (use above categories for this line)

2. State or province ___________ Licensure board ___________
   License number ___________ Issue date ___________ Expiration date ___________

3. State or province ___________ Licensure board ___________
   License number ___________ Issue date ___________ Expiration date ___________

4. State or province ___________ Licensure board ___________
   License number ___________ Issue date ___________ Expiration date ___________

5. State or province ___________ Licensure board ___________
   License number ___________ Issue date ___________ Expiration date ___________

6. State or province ___________ Licensure board ___________
   License number ___________ Issue date ___________ Expiration date ___________

7. State or province ___________ Licensure board ___________
   License number ___________ Issue date ___________ Expiration date ___________

8. State or province ___________ Licensure board ___________
   License number ___________ Issue date ___________ Expiration date ___________

9. State or province ___________ Licensure board ___________
   License number ___________ Issue date ___________ Expiration date ___________
Chronology of Activities

List all activities from medical school graduation to the present date in this section, except for the postgraduate training already entered. Include locum tenens and military assignments, unless otherwise indicated in the state board instructions. For each period of non-working time, describe the events that were happening and list your home address for that time.

If you have additional activities to report, copy the next page as needed, then list the information and attach to this application. Do not substitute any other resume or curriculum vitae for this section.

<table>
<thead>
<tr>
<th>Start date</th>
<th>Description of non-working time</th>
<th>End date</th>
<th>Business or School name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

- In progress
- Address

<table>
<thead>
<tr>
<th>Type of Activity</th>
<th>Postgraduate Training / Education</th>
<th>Work</th>
<th>Military Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seeking Employment</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- PGT and Work only
- Position
- Department

- Clinical time (seeing patients in a clinical setting) ___%
- Administrative time (paperwork, research, etc.) ___%
- I was considered to be on staff or employed in a non-educational training setting.
- I was granted privileges by this institution to see patients and/or otherwise practice medicine.
- I was a visiting professor, consultant, evaluator, or in a position not considered employment or training.

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- PGT and Work only
- Position
- Department

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</tbody>
</table>

- PGT and Work only
- Position
- Department

- Clinical time (seeing patients in a clinical setting) ___%
- Administrative time (paperwork, research, etc.) ___%
- I was considered to be on staff or employed in a non-educational training setting.
- I was granted privileges by this institution to see patients and/or otherwise practice medicine.
- I was a visiting professor, consultant, evaluator, or in a position not considered employment or training.
5. Start date_________ Description of non-working time ____________________________________________
   End date_________ or Business or School name ____________________________________________
   □ In progress  Address _________________________________________________________________
   Type of Activity □ Postgraduate Training / Education □ Work □ Military Service
   □ Seeking Employment  □ Vacation □ Health Issue (non-work)
   PGT and Work only  Position ____________________________________________________________
   Department ____________________________________________________________
   Clinical time (seeing patients in a clinical setting) ___%  Administrative time (paperwork, research, etc.) ___%
   □ I was considered to be on staff or employed in a non-educational training setting.
   □ I was granted privileges by this institution to see patients and/or otherwise practice medicine.
   □ I was a visiting professor, consultant, evaluator, or in a position not considered employment or training.

6. Start date_________ Description of non-working time ____________________________________________
   End date_________ or Business or School name ____________________________________________
   □ In progress  Address _________________________________________________________________
   Type of Activity □ Postgraduate Training / Education □ Work □ Military Service
   □ Seeking Employment  □ Vacation □ Health Issue (non-work)
   PGT and Work only  Position ____________________________________________________________
   Department ____________________________________________________________
   Clinical time (seeing patients in a clinical setting) ___%  Administrative time (paperwork, research, etc.) ___%
   □ I was considered to be on staff or employed in a non-educational training setting.
   □ I was granted privileges by this institution to see patients and/or otherwise practice medicine.
   □ I was a visiting professor, consultant, evaluator, or in a position not considered employment or training.

7. Start date_________ Description of non-working time ____________________________________________
   End date_________ or Business or School name ____________________________________________
   □ In progress  Address _________________________________________________________________
   Type of Activity □ Postgraduate Training / Education □ Work □ Military Service
   □ Seeking Employment  □ Vacation □ Health Issue (non-work)
   PGT and Work only  Position ____________________________________________________________
   Department ____________________________________________________________
   Clinical time (seeing patients in a clinical setting) ___%  Administrative time (paperwork, research, etc.) ___%
   □ I was considered to be on staff or employed in a non-educational training setting.
   □ I was granted privileges by this institution to see patients and/or otherwise practice medicine.
   □ I was a visiting professor, consultant, evaluator, or in a position not considered employment or training.

8. Start date_________ Description of non-working time ____________________________________________
   End date_________ or Business or School name ____________________________________________
   □ In progress  Address _________________________________________________________________
   Type of Activity □ Postgraduate Training / Education □ Work □ Military Service
   □ Seeking Employment  □ Vacation □ Health Issue (non-work)
   PGT and Work only  Position ____________________________________________________________
   Department ____________________________________________________________
   Clinical time (seeing patients in a clinical setting) ___%  Administrative time (paperwork, research, etc.) ___%
   □ I was considered to be on staff or employed in a non-educational training setting.
   □ I was granted privileges by this institution to see patients and/or otherwise practice medicine.
   □ I was a visiting professor, consultant, evaluator, or in a position not considered employment or training.

**Malpractice Liability Claims Information**

For each claim (any formal or informal demand for payment to any organization or person), complete all fields. If there was a private compromise or a claim was settled before initiation of civil action, state that in the specifics area for the claim. Provide all specifics and allegations (who, what, where, when, why) for each event as well as your role in each event. If you have additional claims to report, copy this page as needed, then list the information and attach to this application. Attach all relevant information to this application.

□ I have not had any malpractice claims or suits made against me.
1. Event date ___________ Name of patient involved _______________________________________
   Lawsuit date ___________ Name of the court ____________________________________________

   Case number ___________ Location of event (state) ____________________ Insurance carrier ________________

   Claim status
                      Open/pending          Status
                      Closed/settled
                      Dismissed (nothing paid)

   Amount of judgment/settlement $ ___________ Amount paid on your behalf $ ___________

   Provide specifics (including the allegations and your role) in reference to this adverse event.

2. Event date ___________ Name of patient involved _______________________________________
   Lawsuit date ___________ Name of the court ____________________________________________

   Case number ___________ Location of event (state) ____________________ Insurance carrier ________________

   Claim status
                      Open/pending          Status
                      Closed/settled
                      Dismissed (nothing paid)

   Amount of judgment/settlement $ ___________ Amount paid on your behalf $ ___________

   Provide specifics (including the allegations and your role) in reference to this adverse event.

3. Event date ___________ Name of patient involved _______________________________________
   Lawsuit date ___________ Name of the court ____________________________________________

   Case number ___________ Location of event (state) ____________________ Insurance carrier ________________

   Claim status
                      Open/pending          Status
                      Closed/settled
                      Dismissed (nothing paid)

   Amount of judgment/settlement $ ___________ Amount paid on your behalf $ ___________

   Provide specifics (including the allegations and your role) in reference to this adverse event.
**Additional Instructions**

Refer to the Board’s instructions to determine if verification of each license is needed. If so, see the Licensure Verification Information resource at [http://www.fsmb.org/licensure/uniform-application/](http://www.fsmb.org/licensure/uniform-application/) to determine each board’s verification fee and preferred method.

Review your entries prior to submitting your application and other required materials to the Board.

Refer to the checklist(s) included with the Board’s instructions to ensure you handle all required items.

Retain a copy of everything you send to the Board for your records.

**For Applicants NOT using FCVS for credentials verification**

Have each medical school you attended send verification of your medical education, including transcripts, to the Board. Follow the instructions on the medical education verification form in this packet or on the Board’s website.

Have each postgraduate training program you attended send verification of your training to the Board. Follow the instructions on the postgraduate training verification form in this packet or on the Board’s website.

Have the entity for each examination you took (USMLE/FLEX/SPEX, NBME, NBOME, COMLEX, LMCC, state board, etc.) send your exam score transcripts to the Board. For contact and request information, refer to the UA FAQ at [http://www.fsmb.org/licensure/uniform-application/faq](http://www.fsmb.org/licensure/uniform-application/faq).

When you mail this application, affidavit/authorization, fee, and any other documentation to the Board, mail the following as well:

- A notarized copy of your birth certificate or current, valid passport
- Supporting documentation of any legal name change
- A notarized copy of your medical school diploma
- A notarized copy of your postgraduate training certificate(s)
- A notarized copy of evidence of comprehensive licensing examination passed (USMLE, NBME, COMLEX, LMCC, state board, etc.)
- **International Medical Graduates Only**: Choose one of the following to mail:
  - A notarized copy of your ECFMG Certificate. Also visit [http://www.ecfmg.org/cvs/index.html](http://www.ecfmg.org/cvs/index.html) and request that ECFMG send a status report to the Board.
  - A notarized letter showing successful completion of the Fifth Pathway program. Use the Fifth Pathway verification form in this packet to have your program send verification of your completion to the Board.
Affidavit and Authorization for Release of Information

Applicant: In the presence of a notary public, sign this form with attached photo. If you are using FCVS for credentials verification, consider having that form notarized at the same time. Send the separate notarized FCVS form to FCVS. Do not send this form to FCVS as doing so will delay your licensure.

Send this form to the Oklahoma State Board of Osteopathic Examiners, 4848 N. Lincoln Blvd., Suite 100, Oklahoma City, OK 73105. Include all other required materials.

To the Oklahoma State Board of Osteopathic Examiners,

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application, and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Uniform Application for Physician State Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data, and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge, and exonerate the Board, its agents or representatives, and any person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the Board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the Board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.

Applicant’s signature (must be signed in the presence of a notary)

Applicant’s printed last name, first name, middle initial, and suffix (e.g., Jr.)

Date of signature (must correspond to date of notarization)

[Please note: The Notary Public seal should overlap the bottom of the photo to the left.]

NOTARY

State of ______________________, County of ______________________.

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant’s signature made in my presence on this form with the signature on his/her identifying document.

The statements on this document are subscribed and sworn to before me by the applicant on this day of ____________, 20 __.

Notary Public Signature ____________________________________________ My Notary Commission Expires ____________________________

Oklahoma State Board of Osteopathic Examiners
January 2020

Applicant _______________________________________________________

UA Affidavit and Authorization for Release of Information
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
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.
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 for 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? 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.

- [ ] Academic
- [ ] Unprofessional conduct
- [ ] Behavioral reasons
- [ ] 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 ____________________________
Title ____________________________ Date ____________
Affix institutional seal here
(If no seal is available, this form must be notarized.)
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.
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 __________________________
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.
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 ______________________________________________

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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 explain below.

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___________________________________________________
Title_____________________________ Date __________
Phone number________________________ Fax number __________
Email ______________________________

AFFIX INSTITUTIONAL SEAL HERE
(If no seal is available, this form must be notarized.)

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

Oklahoma State Board of Osteopathic Examiners
January 2020

Applicant __________________ UA Fifth Pathway Verification Form