



## OKLAHOMA OSTEOPATHIC PHYSICIAN AND SURGEON LICENSE APPLICATION PACKET

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. There are no shortcuts. The Board will review your application at one of the regularly-scheduled Board meetings before making a decision to grant you a license. The Board meets quarterly – the third Thursdays of March, June and September and the second Thursday of December.

### **Uniform Application for Physician State Licensure (UA):**

The Oklahoma State Board of Osteopathic Examiners was one of the first boards to incorporate the Uniform Application for Physician State Licensure into its application process. This form will make it easier for physicians to apply for licensure in additional states that utilize the UA. The OSBOE also requires completion of its Pre-Licensing Packet (PLP).

### **The Federation Credentials Verification Service (FCVS):**

The Board highly recommends, but does not require, the use of FCVS to primary source verify core physician credentials as part of the licensure process. FCVS is a service of the Federation of State Medical Boards (FSMB) and was created to assist in license portability for physicians. 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:**

In planning your practice activity, allow an ample timeframe in order to achieve licensure. Our staff must have time to receive and process your application before it is presented to the Board and to determine if it is necessary for you to appear for a personal interview on Board meeting day. Applications not completed by the first day of each meeting month (March, June, September, or December) may not be presented for approval until the next quarterly meeting.

**Even if using FCVS, you must still apply for licensure in the State of Oklahoma by submitting the 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 / Brittney Covert*  
Licensure Specialists  
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 Board stresses that you must provide full details and dates, complete names, addresses and zip codes as required in the application. If you do not, the processing of your application will be delayed.

**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. 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 the report to you. You must mail (do not fax) all of the original report (not photocopies) directly to this board. For questions or assistance, call 800.767.6732 or email [help@npdb.hrsa.gov](mailto:help@npdb.hrsa.gov).

### ADDITIONAL INFORMATION

Postgraduate training must be at least one (1) year of rotating internship, or its equivalent, in an accredited internship or residency program acceptable to the Board. To be deemed "equivalent" to a rotating internship, a first year postgraduate experience must contain the following:

- One (1) month – General Practice
  - One (1) month – OB/GYN
  - One (1) month – General Surgery
  - One (1) month – Pediatrics
  - Two (2) months – General Internal Medicine, and
  - Three (3) months – Selectives, which means any of these core areas or Emergency Medicine, and
  - Three (3) months – Electives, to complete a total of twelve months.
- 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. Every other year *and* if practicing in Oklahoma, one hour of CME must be on the proper prescribing of drugs; the course must be approved by this Board.
- B. You may request a DEA application after you are licensed and have your OBNDD number. (Drug Enforcement Administration – 405.475.7500)
- C. When requesting license verifications from states where you are or have been licensed, request through VeriDoc for each participating board. Details are on their website: [www.veridoc.org](http://www.veridoc.org). Refer to the Licensure Verification Information resource at <http://www.fsmb.org/licensure/uniform-application/> to determine fees and preferred verification method of each verifying board.



OKLAHOMA STATE BOARD OF OSTEOPATHIC EXAMINERS  
4848 North Lincoln Boulevard, Suite 100  
Oklahoma City, OK 73105  
Telephone: 405.528.8625

## ***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: \_\_\_\_\_

### **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)

**Applicant Name** \_\_\_\_\_

<p>1. Have you ever been rejected for membership by, or requested to appear, before any medical or osteopathic society?</p> <p><b>If Yes</b>, 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.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>2. Have you ever been denied the privilege of taking an examination administered by any licensing agency?</p> <p><b>If Yes</b>, please provide the name of the examination and the name of the agency on a separate sheet of paper.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>3. Have you ever been denied a license to practice osteopathic medicine?</p> <p><b>If Yes</b>, please provide full details on a separate page. This must include the state(s), date(s), and reason(s).</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>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?</p> <p><b>If Yes</b>, 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.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>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?</p> <p><b>If Yes</b>, 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.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>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?</p> <p><b>If Yes</b>, 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.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>7. Have you ever, for any reason, lost Board Certification in any specialty?</p> <p><b>If Yes</b>, 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.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>8. Has any licensing authority or disciplinary agency limited, probated, restricted, suspended, or revoked a license or permit you have held?</p> <p><b>If Yes</b>, give full details on a separate page. This should include the state(s), date(s), and reason(s).</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>9. Have you ever voluntarily surrendered a license or permit issued to you by any licensing agency?</p> <p><b>If Yes</b>, give full details on a separate page. This should include the state(s), date(s), and reason(s).</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>10. Have you ever been requested to appear before any licensing or disciplinary agency?</p> <p><b>If Yes</b>, give full details on a separate page. This should include the state(s), date(s), and reason(s).</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>11. Have you ever been notified of any charges or complaints filed against you with any licensing or disciplinary agency?</p> <p><b>If Yes</b>, give full details on a separate page. This should include the state(s), date(s), and reason(s).</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>

**Applicant Name** \_\_\_\_\_

<p>12. Have you ever been diagnosed or treated for any mental or physical illness that would hinder your ability to practice osteopathic medicine?</p> <p><b>If Yes,</b> 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.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>13. Have you ever been chemically dependent?</p> <p><b>If Yes,</b> 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.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>14. Have you ever interrupted your training because of illness or impairment (physical or chemical)?</p> <p><b>If Yes,</b> 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.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>15. Have you ever been unable to practice osteopathic medicine because of illness or impairment?</p> <p><b>If Yes,</b> 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.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>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?</p> <p><b>If Yes,</b> provide full details in a separate notarized statement.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>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?</p> <p><b>If Yes,</b> provide full details, including dates, in a separate notarized statement.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>18. Have you ever surrendered your federal or state controlled substances registration?</p> <p><b>If Yes,</b> provide full details, including dates, in a separate notarized statement.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>19. Have you ever been arrested, fined, charged with, or convicted of a crime, indicted, imprisoned, or placed on probation?</p> <p><b>If Yes,</b> 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.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>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?</p> <p><b>If Yes,</b> 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.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>21. Have you ever been denied provider participation in any state Medicaid or federal Medicare program?</p> <p><b>If Yes,</b> 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.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>

**Applicant Name** \_\_\_\_\_

21. Have you ever been denied provider participation in any state Medicaid or federal Medicare program? <b>If Yes</b> , 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.	Yes <input type="checkbox"/> No <input type="checkbox"/>
22. Have you ever been terminated, sanctioned, penalized, or had to repay monies to any state Medicaid or federal Medicare program? <b>If Yes</b> , 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.	Yes <input type="checkbox"/> No <input type="checkbox"/>
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? <b>If Yes</b> , provide all information required within the Malpractice Liability Claims section of the Uniform Application.	Yes <input type="checkbox"/> No <input type="checkbox"/>
24. Are you now taking prescription medication of any kind? <b>If Yes</b> , 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.	Yes <input type="checkbox"/> No <input type="checkbox"/>

*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.



## 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.

	<b>NOT using FCVS to verify credentials</b>	<b>Using FCVS to verify credentials</b>
Submit the completed Uniform Application (including pre-licensing packet), fees, and other required documentation to the Board.	<input type="checkbox"/>	<input type="checkbox"/>
Enclose fingerprint form or card along with background check fee when submitting this application to the Board.	<input type="checkbox"/>	<input type="checkbox"/>
Send results of the National Practitioner Data Bank self-query directly to the Board. (This may be mailed separately from the completed application.)	<input type="checkbox"/>	<input type="checkbox"/>
Enclose the completed and notarized "Affidavit and Authorization for Release of Information" form when submitting this application to the Board.	<input type="checkbox"/>	<input type="checkbox"/>
Have the State Licensure Verification form (Form #1) sent to the Board from all states in which you have ever held any healthcare license.	<input type="checkbox"/>	<input type="checkbox"/>
Enclose a notarized copy of your birth certificate or current, valid passport when submitting this application to the Board.	<input type="checkbox"/>	Completed via FCVS
Enclose supporting documentation of any legal name change when submitting this application to the Board.	<input type="checkbox"/>	Completed via FCVS
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).	<input type="checkbox"/>	Completed via FCVS
Have the Medical school transcripts sent to the Board by your medical school(s).	<input type="checkbox"/>	Completed via FCVS
Have the Postgraduate Training Verification form (Form #3) sent to the Board from all programs you attended.	<input type="checkbox"/>	Completed via FCVS
Enclose a copy of your postgraduate training certificate(s) when submitting this application to the Board.	<input type="checkbox"/>	Completed via FCVS
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).	<input type="checkbox"/>	Completed via FCVS
Have your Examination Transcripts sent to the Board.	<input type="checkbox"/>	Completed via FCVS
Have a notarized copy of ECFMG Certificate (if applicable) sent to the Board.	<input type="checkbox"/>	Completed via FCVS



## Uniform Application – Core Application

Send this form to: Oklahoma State Board of Osteopathic Examiners  
4848 N. Lincoln Blvd., Suite 100, Oklahoma City, OK 73105-3335

Indicate your full legal name and any other names you have used in the past. If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change to the Board.

Please complete all fields and indicate which address you want to use for public access and at which address you want to receive mailings from the Board. State laws vary on which address or phone number is or is not a matter of public record. Additionally, many state boards publish the Public Access address on their web sites. You may wish to contact the appropriate state licensing authority to determine which information will be a matter of public record.

If you are not using FCVS, you must submit one of the following to the Board: certified birth certificate, notarized copy of your birth certificate, original valid passport, or notarized copy of your current valid passport. Please check the state specific instructions for more information.

Be sure to list your name at the top of each following page.

### Full Name

Last name: \_\_\_\_\_ Suffix: \_\_\_\_\_

First name: \_\_\_\_\_

Middle name: \_\_\_\_\_

Maiden name (if applicable): \_\_\_\_\_

All other names used/identified as: \_\_\_\_\_

\_\_\_\_\_ Degree Type  M.D.  D.O.

### Practice Address

Public Access

Street: \_\_\_\_\_

Mailings for Medical Board

\_\_\_\_\_

City: \_\_\_\_\_

State/Province: \_\_\_\_\_

Zip code: \_\_\_\_\_ Country: \_\_\_\_\_

Practice phone: \_\_\_\_\_ Practice fax: \_\_\_\_\_

Alternate phone: \_\_\_\_\_ Alternate fax: \_\_\_\_\_

Practice email: \_\_\_\_\_

### Home Address

Public Access

Street: \_\_\_\_\_

Mailings for Medical Board

\_\_\_\_\_

City: \_\_\_\_\_

State/Province: \_\_\_\_\_

Zip code: \_\_\_\_\_ Country: \_\_\_\_\_

Home phone: \_\_\_\_\_ Home fax: \_\_\_\_\_

Alternate phone: \_\_\_\_\_ Alternate fax: \_\_\_\_\_

Home email: \_\_\_\_\_

### Identification

Date of birth: \_\_\_\_\_ Gender: \_\_\_\_\_ Birth city: \_\_\_\_\_  
(mm/dd/yyyy)

Birth state/province: \_\_\_\_\_ Birth country: \_\_\_\_\_

Social Security number\*: \_\_\_\_\_ NPI number\*\*: \_\_\_\_\_ U.S. Citizen?  Yes  No  
(9 digits) (10 digits)

\*Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. Section 666 and applicable state law). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with state laws governing physician discipline or as otherwise required by state or federal law.

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

**Applicant Name:** \_\_\_\_\_

List all medical schools you have attended, even those from which you did not graduate, in chronological order. Please copy and attach additional pages if necessary.

If you are not using FCVS, you must complete the Medical Education Verification form and send it to all medical schools you have attended. Include a copy of your diploma to which the medical school must attach their seal prior to forwarding it to the Board.

Additionally, the medical school must provide the Board with an official copy of your transcripts. If transcripts are not in English, an original, certified, and official English translation is required.

If you attended a Fifth Pathway program and are not using FCVS, you must complete the Fifth Pathway Verification form and send it to your medical school and to the institution where you completed your rotations. You must include a copy of your diploma. The medical School and institution must forward all documentation directly to the Board.

If ECFMG is applicable and you are not using FCVS, contact ECFMG and have a certified status report forwarded from them to the Board. There is a separate fee for this report.

**Medical School**

1. Full Name of Medical School: \_\_\_\_\_  
Street: \_\_\_\_\_  
City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip code: \_\_\_\_\_  
Country: \_\_\_\_\_ Attendance dates: From \_\_\_\_\_ to \_\_\_\_\_  
(mm/yyyy) (mm/yyyy)  
Date degree conferred/issued (indicate if not applicable): \_\_\_\_\_  
(mm/dd/yyyy)  
Degree received (as stated on diploma): \_\_\_\_\_  
(indicate if not applicable)
  
2. Full Name of Medical School: \_\_\_\_\_  
Street: \_\_\_\_\_  
City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip code: \_\_\_\_\_  
Country: \_\_\_\_\_ Attendance dates: From \_\_\_\_\_ to \_\_\_\_\_  
(mm/yyyy) (mm/yyyy)  
Date degree conferred/issued (indicate if not applicable): \_\_\_\_\_  
(mm/dd/yyyy)  
Degree received (as stated on diploma): \_\_\_\_\_  
(indicate if not applicable)

**Fifth Pathway**

I did not participate in a Fifth Pathway program.

**Affiliated medical school that awarded the Fifth Pathway Certification**

Full Name of Medical School: \_\_\_\_\_  
Street: \_\_\_\_\_  
City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip code: \_\_\_\_\_  
Country: \_\_\_\_\_ Attendance dates: From \_\_\_\_\_ to \_\_\_\_\_  
(mm/yyyy) (mm/yyyy)  
Date degree conferred/issued: \_\_\_\_\_ Degree (as stated on diploma): \_\_\_\_\_  
(mm/dd/yyyy)

**Hospital or clinic in which you performed the required rotations**

Institution name: \_\_\_\_\_  
Rotation dates: From \_\_\_\_\_ to \_\_\_\_\_ Certificate date: \_\_\_\_\_  
(mm/yyyy) (mm/yyyy) (mm/dd/yyyy)

**ECFMG**

I do not have an ECFMG certificate.

Certificate number: \_\_\_\_\_ Issue date: \_\_\_\_\_  
(mm/dd/yyyy)

**Applicant Name:** \_\_\_\_\_

List all postgraduate programs you have attended, even those you did not complete. Please copy and attach additional pages if necessary.

If you are not using FCVS, you must complete the Postgraduate Training Verification form and send it to all postgraduate training programs you have attended. You must submit a copy of your certificate of program completion to the Board. The postgraduate program must forward all documentation directly to the Board.

**Postgraduate Training**

1. Full Name of Hospital: \_\_\_\_\_  
Street: \_\_\_\_\_  
City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip code: \_\_\_\_\_  
Country: \_\_\_\_\_ Department/Specialty: \_\_\_\_\_  
Affiliated medical school name: \_\_\_\_\_  
Attendance dates: From \_\_\_\_\_ to \_\_\_\_\_ Postgraduate year (e.g., 1, 2, 3, etc.): \_\_\_\_\_  
(mm/yyyy) (mm/yyyy)

<input type="checkbox"/> Chief Resident	<input type="checkbox"/> Internship/Residency	<input type="checkbox"/> Residency	<input type="checkbox"/> Transitional
<input type="checkbox"/> Fellowship	<input type="checkbox"/> Junior Registrar	<input type="checkbox"/> Residency/Chief Residency	
<input type="checkbox"/> Fellowship/Research	<input type="checkbox"/> Preliminary	<input type="checkbox"/> Senior House Officer	<input type="checkbox"/> Unknown
<input type="checkbox"/> House Officer	<input type="checkbox"/> Registrar	<input type="checkbox"/> Senior Registrar	<input type="checkbox"/> Unspecified
<input type="checkbox"/> Internship	<input type="checkbox"/> Research	<input type="checkbox"/> Other: _____	

Successfully completed?  Yes  No  In progress; expected completion in \_\_\_\_\_  
(mm/yyyy)

2. Full Name of Hospital: \_\_\_\_\_  
Street: \_\_\_\_\_  
City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip code: \_\_\_\_\_  
Country: \_\_\_\_\_ Department/Specialty: \_\_\_\_\_  
Affiliated medical school name: \_\_\_\_\_  
Attendance dates: From \_\_\_\_\_ to \_\_\_\_\_ Postgraduate year (e.g., 1, 2, 3, etc.): \_\_\_\_\_  
(mm/yyyy) (mm/yyyy)

<input type="checkbox"/> Chief Resident	<input type="checkbox"/> Internship/Residency	<input type="checkbox"/> Residency	<input type="checkbox"/> Transitional
<input type="checkbox"/> Fellowship	<input type="checkbox"/> Junior Registrar	<input type="checkbox"/> Residency/Chief Residency	
<input type="checkbox"/> Fellowship/Research	<input type="checkbox"/> Preliminary	<input type="checkbox"/> Senior House Officer	<input type="checkbox"/> Unknown
<input type="checkbox"/> House Officer	<input type="checkbox"/> Registrar	<input type="checkbox"/> Senior Registrar	<input type="checkbox"/> Unspecified
<input type="checkbox"/> Internship	<input type="checkbox"/> Research	<input type="checkbox"/> Other: _____	

Successfully completed?  Yes  No  In progress; expected completion in \_\_\_\_\_  
(mm/yyyy)

3. Full Name of Hospital: \_\_\_\_\_  
Street: \_\_\_\_\_  
City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip code: \_\_\_\_\_  
Country: \_\_\_\_\_ Department/Specialty: \_\_\_\_\_  
Affiliated medical school name: \_\_\_\_\_  
Attendance dates: From \_\_\_\_\_ to \_\_\_\_\_ Postgraduate year (e.g., 1, 2, 3, etc.): \_\_\_\_\_  
(mm/yyyy) (mm/yyyy)

<input type="checkbox"/> Chief Resident	<input type="checkbox"/> Internship/Residency	<input type="checkbox"/> Residency	<input type="checkbox"/> Transitional
<input type="checkbox"/> Fellowship	<input type="checkbox"/> Junior Registrar	<input type="checkbox"/> Residency/Chief Residency	
<input type="checkbox"/> Fellowship/Research	<input type="checkbox"/> Preliminary	<input type="checkbox"/> Senior House Officer	<input type="checkbox"/> Unknown
<input type="checkbox"/> House Officer	<input type="checkbox"/> Registrar	<input type="checkbox"/> Senior Registrar	<input type="checkbox"/> Unspecified
<input type="checkbox"/> Internship	<input type="checkbox"/> Research	<input type="checkbox"/> Other: _____	

Successfully completed?  Yes  No  In progress; expected completion in \_\_\_\_\_  
(mm/yyyy)

**Applicant Name:** \_\_\_\_\_

List the information for each licensure exam you have taken, whether U.S. or international (USMLE, LLMCC, NBME, etc.).

If you are not using FCVS, you must contact the appropriate examination entity and have them send a certified transcript of your scores directly to the Board.

**Examination History**

<u>Examination</u>	<u>Most recent date taken</u> (mm/yyyy)	<u>Passed/Failed/Unknown</u>	<u>Number of attempts</u>
FLEX Pre-1985	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
FLEX Component 1	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
FLEX Component 2	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
LMCC – Single	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
LMCC – Part I	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
LMCC – Part II	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
NBME Part I	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
NBME Part II	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
NBME Part III	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
SPEX	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
NBOME Part I	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
NBOME Part II	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
NBOME Part III	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
COMLEX-USA Level 1	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
COMLEX-USA Level 2, CE	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
COMLEX-USA Level 2, PE	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
COMLEX-USA Level 3	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
COMVEX	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
USMLE Step I	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
USMLE Step II, CS	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
USMLE Step II, CK	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
USMLE Step III	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
State Board Exam			
State: _____	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
State: _____	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
State: _____	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
State: _____	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____

List all state and Canadian provinces where you currently hold or have ever held any type of health care related license. Please copy and attach additional pages if necessary.

You must also complete the Licensure Verification form and send it to all states in which you have held any health care license or certification. Some state boards charge a fee for this information. The verifying entity must forward all licensure documentation to the Board.

**State/Province Professional Licensure**

1. Practitioner license type:  Full license  Temporary  Training  Limited

<input type="checkbox"/> Doctor of Medicine	<input type="checkbox"/> Nurse Practitioner
<input type="checkbox"/> Doctor of Osteopathic Medicine	<input type="checkbox"/> Licensed Practical Nurse
<input type="checkbox"/> Doctor of Dental Surgery	<input type="checkbox"/> Registered Nurse
<input type="checkbox"/> Doctor of Dental Medicine	<input type="checkbox"/> Physician Assistant
<input type="checkbox"/> Doctor of Psychology	<input type="checkbox"/> Emergency Medical Technician
<input type="checkbox"/> Doctor of Podiatric Medicine	<input type="checkbox"/> Other (please specify) _____
<input type="checkbox"/> Doctor of Chiropractic	

State/Province: \_\_\_\_\_ License number: \_\_\_\_\_ Issue date: \_\_\_\_\_

License status:  Active  Expired  In Good Standing

Inactive  Limited  Probationary

Restricted  Retired  Revoked  Suspended

**Applicant Name:** \_\_\_\_\_

Please copy and attach additional pages if necessary.

2. Practitioner license type:  Full license  Temporary  Training  Limited

<input type="checkbox"/> Doctor of Medicine	<input type="checkbox"/> Nurse Practitioner
<input type="checkbox"/> Doctor of Osteopathic Medicine	<input type="checkbox"/> Licensed Practical Nurse
<input type="checkbox"/> Doctor of Dental Surgery	<input type="checkbox"/> Registered Nurse
<input type="checkbox"/> Doctor of Dental Medicine	<input type="checkbox"/> Physician Assistant
<input type="checkbox"/> Doctor of Psychology	<input type="checkbox"/> Emergency Medical Technician
<input type="checkbox"/> Doctor of Podiatric Medicine	<input type="checkbox"/> Other (please specify) _____
<input type="checkbox"/> Doctor of Chiropractic	_____

State/Province: \_\_\_\_\_ License number: \_\_\_\_\_ Issue date: \_\_\_\_\_

License status:  Active  Expired  In Good Standing  
 Inactive  Limited  Probationary  
 Restricted  Retired  Revoked  Suspended

3. Practitioner license type:  Full license  Temporary  Training  Limited

<input type="checkbox"/> Doctor of Medicine	<input type="checkbox"/> Nurse Practitioner
<input type="checkbox"/> Doctor of Osteopathic Medicine	<input type="checkbox"/> Licensed Practical Nurse
<input type="checkbox"/> Doctor of Dental Surgery	<input type="checkbox"/> Registered Nurse
<input type="checkbox"/> Doctor of Dental Medicine	<input type="checkbox"/> Physician Assistant
<input type="checkbox"/> Doctor of Psychology	<input type="checkbox"/> Emergency Medical Technician
<input type="checkbox"/> Doctor of Podiatric Medicine	<input type="checkbox"/> Other (please specify) _____
<input type="checkbox"/> Doctor of Chiropractic	_____

State/Province: \_\_\_\_\_ License number: \_\_\_\_\_ Issue date: \_\_\_\_\_

License status:  Active  Expired  In Good Standing  
 Inactive  Limited  Probationary  
 Restricted  Retired  Revoked  Suspended

4. Practitioner license type:  Full license  Temporary  Training  Limited

<input type="checkbox"/> Doctor of Medicine	<input type="checkbox"/> Nurse Practitioner
<input type="checkbox"/> Doctor of Osteopathic Medicine	<input type="checkbox"/> Licensed Practical Nurse
<input type="checkbox"/> Doctor of Dental Surgery	<input type="checkbox"/> Registered Nurse
<input type="checkbox"/> Doctor of Dental Medicine	<input type="checkbox"/> Physician Assistant
<input type="checkbox"/> Doctor of Psychology	<input type="checkbox"/> Emergency Medical Technician
<input type="checkbox"/> Doctor of Podiatric Medicine	<input type="checkbox"/> Other (please specify) _____
<input type="checkbox"/> Doctor of Chiropractic	_____

State/Province: \_\_\_\_\_ License number: \_\_\_\_\_ Issue date: \_\_\_\_\_

License status:  Active  Expired  In Good Standing  
 Inactive  Limited  Probationary  
 Restricted  Retired  Revoked  Suspended

5. Practitioner license type:  Full license  Temporary  Training  Limited

<input type="checkbox"/> Doctor of Medicine	<input type="checkbox"/> Nurse Practitioner
<input type="checkbox"/> Doctor of Osteopathic Medicine	<input type="checkbox"/> Licensed Practical Nurse
<input type="checkbox"/> Doctor of Dental Surgery	<input type="checkbox"/> Registered Nurse
<input type="checkbox"/> Doctor of Dental Medicine	<input type="checkbox"/> Physician Assistant
<input type="checkbox"/> Doctor of Psychology	<input type="checkbox"/> Emergency Medical Technician
<input type="checkbox"/> Doctor of Podiatric Medicine	<input type="checkbox"/> Other (please specify) _____
<input type="checkbox"/> Doctor of Chiropractic	_____

State/Province: \_\_\_\_\_ License number: \_\_\_\_\_ Issue date: \_\_\_\_\_

License status:  Active  Expired  In Good Standing  
 Inactive  Limited  Probationary  
 Restricted  Retired  Revoked  Suspended

**Applicant Name:** \_\_\_\_\_

List ALL activities (medical, non-medical, and postgraduate training) in chronological order beginning with medical school graduation to the PRESENT date, indicating month and year.

\* For any non-working time, you MUST state exactly what your activities were, such as "vacation" or "seeking employment." List your permanent/home address for that time.

If you worked for a physician-staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses.

DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS SECTION.

\*\* Clinical indicates the percentage of time spent with patients.

\*\*\* Administrative indicates the percentage of time spent on administrative tasks like paperwork, etc.

Please copy and attach additional pages as necessary.

**Chronology of Activities**

1. Start date: \_\_\_\_\_ End date: \_\_\_\_\_  
(mm/yyyy) (mm/yyyy)

Type of Activity:  Health activity (non-working time due to health reasons)  
 Military service  Postgraduate training/education  
 Seeking employment  Vacation  Work

Practice/Employment Name **or** Description of non-working time\*: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip code: \_\_\_\_\_

Country: \_\_\_\_\_ Position: \_\_\_\_\_

Department: \_\_\_\_\_ Clinical\*\*: \_\_\_\_% Administrative\*\*\*: \_\_\_\_%

Employment  Staff Privileges  Affiliation  
 Other (describe your relationship with this institution): \_\_\_\_\_

2. Start date: \_\_\_\_\_ End date: \_\_\_\_\_  
(mm/yyyy) (mm/yyyy)

Type of Activity:  Health activity (non-working time due to health reasons)  
 Military service  Postgraduate training/education  
 Seeking employment  Vacation  Work

Practice/Employment Name **or** Description of non-working time\*: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip code: \_\_\_\_\_

Country: \_\_\_\_\_ Position: \_\_\_\_\_

Department: \_\_\_\_\_ Clinical\*\*: \_\_\_\_% Administrative\*\*\*: \_\_\_\_%

Employment  Staff Privileges  Affiliation  
 Other (describe your relationship with this institution): \_\_\_\_\_

3. Start date: \_\_\_\_\_ End date: \_\_\_\_\_  
(mm/yyyy) (mm/yyyy)

Type of Activity:  Health activity (non-working time due to health reasons)  
 Military service  Postgraduate training/education  
 Seeking employment  Vacation  Work

Practice/Employment Name **or** Description of non-working time\*: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip code: \_\_\_\_\_

Country: \_\_\_\_\_ Position: \_\_\_\_\_

Department: \_\_\_\_\_ Clinical\*\*: \_\_\_\_% Administrative\*\*\*: \_\_\_\_%

Employment  Staff Privileges  Affiliation  
 Other (describe your relationship with this institution): \_\_\_\_\_

**Applicant Name:** \_\_\_\_\_

Please copy and attach additional pages as necessary.

4. Start date: \_\_\_\_\_ End date: \_\_\_\_\_  
(mm/yyyy) (mm/yyyy)

Type of Activity:  Health activity (non-working time due to health reasons)  
 Military service  Postgraduate training/education  
 Seeking employment  Vacation  Work

Practice/Employment Name **or** Description of non-working time\*: \_\_\_\_\_  
\_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip code: \_\_\_\_\_

Country: \_\_\_\_\_ Position: \_\_\_\_\_

Department: \_\_\_\_\_ Clinical\*\*: \_\_\_\_% Administrative\*\*\*: \_\_\_\_%

Employment  Staff Privileges  Affiliation  
 Other (describe your relationship with this institution): \_\_\_\_\_

5. Start date: \_\_\_\_\_ End date: \_\_\_\_\_  
(mm/yyyy) (mm/yyyy)

Type of Activity:  Health activity (non-working time due to health reasons)  
 Military service  Postgraduate training/education  
 Seeking employment  Vacation  Work

Practice/Employment Name **or** Description of non-working time\*: \_\_\_\_\_  
\_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip code: \_\_\_\_\_

Country: \_\_\_\_\_ Position: \_\_\_\_\_

Department: \_\_\_\_\_ Clinical\*\*: \_\_\_\_% Administrative\*\*\*: \_\_\_\_%

Employment  Staff Privileges  Affiliation  
 Other (describe your relationship with this institution): \_\_\_\_\_

6. Start date: \_\_\_\_\_ End date: \_\_\_\_\_  
(mm/yyyy) (mm/yyyy)

Type of Activity:  Health activity (non-working time due to health reasons)  
 Military service  Postgraduate training/education  
 Seeking employment  Vacation  Work

Practice/Employment Name **or** Description of non-working time\*: \_\_\_\_\_  
\_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip code: \_\_\_\_\_

Country: \_\_\_\_\_ Position: \_\_\_\_\_

Department: \_\_\_\_\_ Clinical\*\*: \_\_\_\_% Administrative\*\*\*: \_\_\_\_%

Employment  Staff Privileges  Affiliation  
 Other (describe your relationship with this institution): \_\_\_\_\_

Please copy and attach additional pages as necessary.

**Applicant Name:** \_\_\_\_\_

You must complete this section to report all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization.

\* If private compromise or settled before initiation of civil action, state on this line.

All fields are required to be answered. Please have your information available before starting this section.

Please copy and attach additional pages if necessary.

### **Malpractice Liability Claims Information**

I have not had any malpractice claims or suits made against me.

1. Name of patient involved: \_\_\_\_\_

In which state, territory, or province did the action take place? \_\_\_\_\_

Which court\*? \_\_\_\_\_

Case number (if applicable) \_\_\_\_\_ Month and year of lawsuit: \_\_\_\_\_

Month and year of event precipitating claim: \_\_\_\_\_

Current claim status:  Closed (settled)  Dismissed (no money paid out)  
 Open (pending)  Other: \_\_\_\_\_

Amount of judgment or settlement: \$\_\_\_\_\_ Amount paid on your behalf: \$\_\_\_\_\_

What is/was your status?  Primary Defendant  Co-Defendant  
 Other (specify): \_\_\_\_\_

Insurance carrier at the time: \_\_\_\_\_

Please provide specifics in reference to the adverse event, including the allegations and your role in the event, in the space below. Use another sheet of paper or the back of this form if necessary.

Complete the following forms as instructed.

- Pre-Licensing Packet
- Affidavit and Authorization for Release of Information
- Form #1: Licensure Verification Form

If you are using FCVS, you do not have to complete forms 2, 3, and 4.

- Form #2: Medical School Verification
- Form #3: Postgraduate Training Verification
- Form #4: Fifth Pathway Verification (if applicable)

### **Review & Submit**

Please review all of your entries prior to submission. Be sure to include all forms and fees. You are strongly advised to keep a copy for your records.



Affidavit and Authorization for Release of Information

Applicant: Complete as instructed in the left sidebar. Send this notarized form to the Oklahoma State Board of Osteopathic Examiners.

Applicant:

This is a separate form from the FCVS affidavit and release.

If you are using FCVS for credentials verification, you must complete both FCVS and UA affidavits. Send the FCVS affidavit to FCVS.

Sign this form with attached photo in the presence of a notary public.

Send this notarized form to the Oklahoma State Board of Osteopathic Examiners.

DO NOT SEND THIS FORM TO FCVS/FSMB. Doing so will cause a delay in your licensure process.

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 Photograph

Securely tape or glue a recent (less than 6 month old) front-view 2" x 2" passport-type color photo of yourself in the square below.

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

Applicant's printed last name

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

Date of signature (must correspond to date of notarization)

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: \_\_\_\_\_

(NOTARY PUBLIC SEAL)

My Notary Commission Expires: \_\_\_\_\_



## Licensure Verification (UA Form #1)

Applicant: Complete as instructed in the left sidebar.

Licensing Board: Complete as instructed in the left sidebar.

**Applicant:**

Complete Section 1. Send this completed form and any applicable fee to each state board you have held a full, temporary, training, or limited license with.

Licensure Verification Information (including fees) is available at <http://www.fsmb.org/licensure/uniform-application/>.

Copy this form for multiple licenses.

### Section 1: Applicant Information

Last name: \_\_\_\_\_ Suffix: \_\_\_\_\_

First name: \_\_\_\_\_

Middle name: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Social Security number\*: \_\_\_\_\_

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

**Authorization:** I am applying for a license to practice medicine. The Board I am applying to requires that this form be completed by each state or Canadian province in 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 license number \_\_\_\_\_ to the following Board:

Board name: Oklahoma State Board of Osteopathic Examiners

Board address: 4848 N. Lincoln Blvd., Suite 100

City/State/Zip: Oklahoma City, OK 73105-3335

**Applicant signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Licensing Board:**

Please complete Section 2 of this form.

Send this form to the state board listed in Section 1.

Alternatively, provide electronic verification of licensure to the state board listed in Section 1.

**DO NOT SEND THIS FORM OR ANY VERIFICATIONS TO FCVS/FSMB.**

### Section 2: Licensure Verification

Name of Licensee: \_\_\_\_\_  
Last First Middle Suffix

Issuing State Board: \_\_\_\_\_ License type: \_\_\_\_\_

License number: \_\_\_\_\_ Issue date: \_\_\_\_\_ Expiration date: \_\_\_\_\_

Is this license current?  Yes  No If not current, please explain: \_\_\_\_\_

1. Have formal disciplinary proceedings been initiated against applicant's license by a disciplinary authority in your state?  Yes  No  Cannot answer under state law

If yes, please explain: \_\_\_\_\_

2. 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?

Yes  No  Cannot answer under state law

If yes, please explain: \_\_\_\_\_

**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: \_\_\_\_\_

AFFIX BOARD SEAL HERE

Print name: \_\_\_\_\_

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

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Email: \_\_\_\_\_



## Medical School Verification (UA Form #2)

Applicant: Complete as instructed in the left sidebar.

Dean/Designated Medical School Official: Complete as instructed in the left sidebar.

**Applicant:**

This form is not needed if you are using FCVS for credentials verification.

Complete Section 1 and fill in your name at the top of page 2. Type or print legibly.

Send this completed form and a copy of your medical school diploma to the current Dean of your medical school.

Copy this form for multiple schools.

### Section 1: Applicant Information

Last name: \_\_\_\_\_ Suffix: \_\_\_\_\_

First name: \_\_\_\_\_

Middle name: \_\_\_\_\_

Name if different when diploma awarded: \_\_\_\_\_

Name of medical school: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Social Security number\*: \_\_\_\_\_

*\*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 authorize the medical school listed above to provide any and all information pertaining to my medical education at that institution to the Board 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), then return this form, the sealed diploma, and a copy of my official transcripts to the Board listed below at the given address.

Board name: Oklahoma State Board of Osteopathic Examiners

Board address: 4848 N. Lincoln Blvd., Suite 100

City/State/Zip: Oklahoma City, OK 73105-3335

**Applicant signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Dean or Designated Official:**

Please complete Section 2 of this form, and certify the enclosed copy of the above named applicant's diploma by placing your school seal on it.

Mail the sealed diploma and an official copy of the transcripts of the above named physician with this form and any attachments to the state board listed in Section 1.

**DO NOT MAIL THIS FORM TO FCVS/FSMB.**

If transcripts are not in English, an original, certified, and official English translation is required.

### Section 2: Medical School Verification

Medical school name: \_\_\_\_\_

School name if different when the above applicant attended: \_\_\_\_\_

Medical school address (including city, state or province, zip code, and country as applicable):  
\_\_\_\_\_  
\_\_\_\_\_

Hours of undergraduate education required for admission into your school: \_\_\_\_\_

Total weeks of education applicant attended your school: \_\_\_\_\_

Applicant's attendance dates: From \_\_\_\_\_ to \_\_\_\_\_

Graduation date: \_\_\_\_\_ Degree: \_\_\_\_\_  
(indicate N/A if not applicable) (indicate N/A if not applicable)

The questions on the following page apply to unusual circumstances that occurred during any part of the individual's medical education. Please check the appropriate response(s) and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation. Attach additional pages as necessary.

**Applicant Name:** \_\_\_\_\_

1. Do the official records for this individual reflect (an) interruption(s) or extension(s) in his/her medical education? Yes  No

If yes, please select the reason(s), indicate the dates of the interruption(s) or extension(s), and indicate whether the interruption(s)/extension(s) was/were approved or unapproved.

	From Month/Year	To Month/Year	Approved	Unapproved
<input type="checkbox"/> Personal/Family	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Academic remediation	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Health	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Financial	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Participation in joint degree program (e.g., MD/PhD)	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Participation in non-research special study (e.g., fellowship, international experience)	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other: _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

2. Do the official records for this individual reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? Yes  No

If yes, please select the reason(s) for the probation, indicate the date(s) of placement on and removal from probation, and attach documentation/information of the circumstances and outcome(s).

	From Month/Year	To Month/Year
<input type="checkbox"/> Academic probation	_____	_____
<input type="checkbox"/> Probation for unprofessional conduct/behavioral reasons	_____	_____
<input type="checkbox"/> Probation for other reason(s) (please specify): _____	_____	_____

3. Do the official records for this individual reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? Yes  No

If yes, please attach documentation/information of the circumstances and outcome(s).

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 school or parent university? Yes  No

If yes, please attach documentation/information of the circumstances and outcome(s).

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? Yes  No

If yes, please attach documentation/information of the nature of the limitations or special requirements.

**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.)



## Postgraduate Training Verification (UA Form #3)

Applicant: Complete as instructed in the left sidebar.

Program Director or Designated Official: Complete as instructed in the left sidebar.

**Applicant:**

This form is not needed if you are using FCVS for credentials verification.

Complete Section 1 and fill in your name at the top of page 2. Type or print legibly.

Send this completed form to the current Program Director of your postgraduate training program.

Copy this form for multiple training programs.

### Section 1: Applicant Information

Last name: \_\_\_\_\_ Suffix: \_\_\_\_\_

First name: \_\_\_\_\_

Middle name: \_\_\_\_\_

Name if different when diploma awarded: \_\_\_\_\_

Name of postgraduate training program: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Social Security number\*: \_\_\_\_\_

*\*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 authorize the postgraduate training program listed above to provide any and all information pertaining to my medical education at that institution to the Board listed below. I request that the Program Director or designated official complete Section 2 of this form and send it to the Board listed below at the given address.

Board name: Oklahoma State Board of Osteopathic Examiners

Board address: 4848 N. Lincoln Blvd., Suite 100

City/State/Zip: Oklahoma City, OK 73105-3335

**Applicant signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Program Director or Designated Official:**

Please complete Section 2. Report incomplete years separately from those that were completed successfully. Report each Internship, Residency, and Fellowship separately.

Use one section per specialty/subspecialty and provide a schedule of rotations if the specialty/subspecialty is rotating/transitional.

Make copies and attach additional pages if necessary.

Send this form to the board listed in Section 1 with any added documentation, if applicable.

**DO NOT MAIL THIS FORM TO FCVS/FSMB.**

### Section 2: Postgraduate Training Verification

Institution name: \_\_\_\_\_

Institution address: \_\_\_\_\_

Institution city / state or province / zip code: \_\_\_\_\_

Affiliated medical school name: \_\_\_\_\_

Institution / school name if different when the applicant attended: \_\_\_\_\_

Postgraduate year (e.g., 1, 2, 3, etc.): \_\_\_\_\_  Internship  Residency  Fellowship

Research  Chief Residency  Other: \_\_\_\_\_

Specialty/Subspecialty: \_\_\_\_\_

Attendance dates: From \_\_\_\_\_ to \_\_\_\_\_

Successfully completed\*?  Yes  No  In progress with expected completion date of \_\_\_\_\_

*\*In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?*

Accredited by:  ACGME  AOA  LCGME  RSC  CFPC  
 RCPSC  APPAP  None of these

**Applicant Name:** \_\_\_\_\_

Postgraduate year (e.g., 1, 2, 3, etc.): \_\_\_\_\_  Internship  Residency  Fellowship  
 Research  Chief Residency  Other: \_\_\_\_\_

Specialty/Subspecialty: \_\_\_\_\_

Attendance dates: From \_\_\_\_\_ to \_\_\_\_\_

Successfully completed\*?  Yes  No  In progress with expected completion date of \_\_\_\_\_

*\*In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?*

Accredited by:  ACGME  AOA  LCGME  RSC  CFPC  
 RCPSC  APPAP  None of these

Postgraduate year (e.g., 1, 2, 3, etc.): \_\_\_\_\_  Internship  Residency  Fellowship  
 Research  Chief Residency  Other: \_\_\_\_\_

Specialty/Subspecialty: \_\_\_\_\_

Attendance dates: From \_\_\_\_\_ to \_\_\_\_\_

Successfully completed\*?  Yes  No  In progress with expected completion date of \_\_\_\_\_

*\*In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?*

Accredited by:  ACGME  AOA  LCGME  RSC  CFPC  
 RCPSC  APPAP  None of these

Please explain any "Yes" response on an additional page or in the blank sidebar area above.

**Unusual Circumstances**

- 1. Did this individual ever take a leave of absence or break from his/her 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: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Phone number: \_\_\_\_\_ Fax number: \_\_\_\_\_

Email: \_\_\_\_\_

AFFIX INSTITUTIONAL SEAL HERE

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



## Fifth Pathway Verification (UA Form #4)

Applicant: Complete as instructed in the left sidebar.  
Program Director or Designated Official: Complete as instructed in the left sidebar.

**Applicant:**

This form is not needed if you are using FCVS for credentials verification.

Complete Section 1 and fill in your name at the top of page 2. Type or print legibly.

Send this completed form to your Fifth Pathway director.

### Section 1: Applicant Information

Last name: \_\_\_\_\_ Suffix: \_\_\_\_\_

First name: \_\_\_\_\_

Middle name: \_\_\_\_\_

Name if different when certificate awarded: \_\_\_\_\_

Name of medical school: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Social Security number\*: \_\_\_\_\_

*\*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 authorize the Program Director or designated official of the Fifth Pathway program to provide any and all information pertaining to my medical education at that institution to the Board listed below. I request that the Program Director or designated official complete Section 2 of this form and send it to the Board listed below at the given address.

Board name: Oklahoma State Board of Osteopathic Examiners

Board address: 4848 N. Lincoln Blvd., Suite 100

City/State/Zip: Oklahoma City, OK 73105-3335

**Applicant signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Program Director or Designated Official:**

Please complete all of Section 2.

Send this form to the board listed in Section 1 with any added documentation, if applicable.

DO NOT MAIL THIS FORM TO FCVS/FSMB.

### Section 2: Fifth Pathway Verification

Institution name: \_\_\_\_\_

Institution address: \_\_\_\_\_

Institution city / state or province / zip code: \_\_\_\_\_

Institution / school name if different when the applicant attended: \_\_\_\_\_

Enrollment dates: From \_\_\_\_\_ to \_\_\_\_\_

Completed?  Yes. Certification date: \_\_\_\_\_

No. Withdrawal date: \_\_\_\_\_

No. Dismissal date: \_\_\_\_\_

In progress. Expected completion date: \_\_\_\_\_

If the applicant withdrew or was dismissed, please explain in the space below. Attach additional information if needed.

**Applicant Name:** \_\_\_\_\_

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

**Unusual Circumstances**

1. Did this individual ever take a leave of absence or break from his/her 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

Please explain any "Yes" response in the blank space below. Attach additional information if needed.

**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.**

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

Signature: \_\_\_\_\_  
Print name: \_\_\_\_\_  
Title: \_\_\_\_\_  
Date: \_\_\_\_\_  
Phone number: \_\_\_\_\_ Fax number: \_\_\_\_\_  
Email: \_\_\_\_\_