



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

**OSBOE Application (PLP)**  
(For Temporary Resident License and Resident Training License)

FULL NAME OF APPLICANT: \_\_\_\_\_

Name as you want it to appear on your license: \_\_\_\_\_

Applicant's Birth Date: \_\_\_\_\_

Birth City: \_\_\_\_\_ Birth State: \_\_\_\_\_ Birth Country: \_\_\_\_\_

Osteopathic Specialty: \_\_\_\_\_

Board Certified:  Yes  No **If Yes**, by which board? \_\_\_\_\_

CURRENT practice activity:  PGY 1  Resident  Fellowship  Private  Other (explain):

\_\_\_\_\_

Program work location address / Program Director Name and Telephone Number:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Home Address:

\_\_\_\_\_

\_\_\_\_\_

Mailing Address (This is where your license will be mailed):

\_\_\_\_\_

\_\_\_\_\_

Contact Telephone Numbers:

Cell: \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_

Other: \_\_\_\_\_

Name of Undergraduate School (Not Medical School): \_\_\_\_\_

City/State: \_\_\_\_\_ Graduation Year: \_\_\_\_\_

Name of Medical School: \_\_\_\_\_

City/State: \_\_\_\_\_ Graduation Year: \_\_\_\_\_



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**OSBOE Application (PLP)**  
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Continued...

**TYPE OF LICENSE:**

- Temporary Resident License \_\_\_\_
- Resident Training License \_\_\_\_

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

1. PLP Packet – all 7 pages of this packet
2. Letter from the current training program stating the applicant meets all the requirements for licensure.
3. Cashier's Check
  - Temporary Resident License \$100
  - Resident Training License \$120

**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.

