



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 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. 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
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 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.

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. 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>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.</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>If Yes, 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>If Yes, 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>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.</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>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.</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>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.</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>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.</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>If Yes, 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>If Yes, 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>If Yes, 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>If Yes, 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>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.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>13. Have you ever been chemically dependent?</p> <p>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.</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>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.</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>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.</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>If Yes, 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>If Yes, 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>If Yes, 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>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.</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>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.</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>If Yes, give full details including dates and the names and addresses of the Medicaid or Medicare program in a separate notarized statement. Furnish a separate letter, addressed to each, authorizing them to release whatever information this Board may require.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>

Applicant Name _____

22. Have you ever been terminated, sanctioned, penalized, or had to repay monies to any state Medicaid or federal Medicare program? If Yes , give full details including dates and the names and addresses of the Medicaid or Medicare program in a separate notarized statement. Furnish a separate letter, addressed to each, authorizing them to release whatever information this Board may require.	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? If Yes , 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? If Yes , provide the pertinent information regarding the illness, giving rise to the need for the medication, the name of the drug(s), dosage, etc., in a separate notarized statement. This statement should also discuss who prescribes your medication, where you obtain it, etc. Provide a letter addressed to each prescribing physician, pharmacy, and/or other entity, authorizing them to release any information this Board may require.	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.

	NOT using FCVS to verify credentials	Using FCVS to verify credentials
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) or other form of verification 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

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. Fingerprint cards and other background check materials will be sent to the home address.

Home address _____
 Personal phone number _____ Personal email _____
 Business address _____
 Business phone number _____ Business email _____

Select an address, phone number, and email for receiving board mailings and for listing as public access. Board and public selections may be the same. Contact the board to determine what is considered a matter of public record in that state.

Board contact address	<input type="checkbox"/> Home	<input type="checkbox"/> Business	Public access address	<input type="checkbox"/> Home	<input type="checkbox"/> Business
Board contact phone	<input type="checkbox"/> Personal	<input type="checkbox"/> Business	Public access phone	<input type="checkbox"/> Personal	<input type="checkbox"/> Business
Board contact email	<input type="checkbox"/> Personal	<input type="checkbox"/> Business	Public access email	<input type="checkbox"/> Personal	<input type="checkbox"/> Business

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)

<input type="checkbox"/> BM	<input type="checkbox"/> BMBCH	<input type="checkbox"/> MBBS	<input type="checkbox"/> DM	<input type="checkbox"/> DMCH	<input type="checkbox"/> DMMS	<input type="checkbox"/> DMS
<input type="checkbox"/> DO	<input type="checkbox"/> DOM	<input type="checkbox"/> MBCHB	<input type="checkbox"/> MBBS	<input type="checkbox"/> MBCHB	<input type="checkbox"/> MD	<input type="checkbox"/> MDCHM
<input type="checkbox"/> MDMCH	<input type="checkbox"/> MDMS	<input type="checkbox"/> MDPHD	<input type="checkbox"/> MSMD	<input type="checkbox"/> PA	<input type="checkbox"/> PHYS	<input type="checkbox"/> 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.

Program Type		Accreditation	Training Status
Internship	Jr. Registrar	ACGME (Accreditation Council for Graduate Medical Education)	Completed
Categorical	Registrar	AOA (American Osteopathic Association)	Dismissed
Transitional	Sr. Registrar	APPAP (Associate of Postgraduate Physician Assistant Programs)	In training
Preliminary	House Officer	CFPC (The College of Family Physicians Canada)	Leave of absence
Rotational	Sr. House Officer	LCGME (Liaison Committee for Graduate Medical Education)	Not started
Residency	Fellowship	RCPSC (The Royal College of Physicians and Surgeons of Canada)	Withdrawn
Internship/Residency	Research	RSC (Royal Society of Chemistry)	

1. Start date _____ 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 _____ Institution name _____
 End date _____ Complete address _____
 In progress Training area _____ Specialty _____
 Program year(s) _____ Affiliated school _____
 Program type _____ Accreditation _____ Training status _____

3. Start date _____ Institution name _____
 End date _____ Complete address _____
 In progress Training area _____ Specialty _____
 Program year(s) _____ Affiliated school _____
 Program type _____ Accreditation _____ Training status _____

4. Start date _____ Institution name _____
 End date _____ Complete address _____
 In progress Training area _____ Specialty _____
 Program year(s) _____ Affiliated school _____
 Program type _____ Accreditation _____ Training status _____

5. Start date _____ 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>.

Examination	Most recent date taken	Passed/Failed	Number of attempts
USMLE Step 1	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F)	____
USMLE Step 2 CS	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F)	____
USMLE Step 2 CK	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F)	____
USMLE Step 3	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F)	____
FLEX Pre-1985	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F)	____
FLEX Component 1	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F)	____
FLEX Component 2	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F)	____
SPEX	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F)	____
NBME Part I	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F)	____
NBME Part II	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F)	____
NBME Part III	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F)	____
NBOME Part I	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F)	____
NBOME Part II	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F)	____
NBOME Part III	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F)	____
COMLEX Level 2	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F)	____
NBOME-COMLEX Level 1	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F)	____
NBOME-COMLEX Level 2 CE	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F)	____
NBOME-COMLEX Level 2 PE	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F)	____
NBOME-COMLEX Level 3	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F)	____
NBPE Part III	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F)	____
PMLexis	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F)	____
LMCC Part A	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F)	____
LMCC Part B	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F)	____
LMCC Qualifying Exam Part I	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F)	____
LMCC Qualifying Exam Part II	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F)	____
LMCC Single Exam	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F)	____
PA National Certifying Exam	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F)	____
PA National Recertification Exam	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F)	____
State Board _____	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F)	____
State Board _____	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F)	____

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> 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.

Practitioner License Type	License Type	License Status		
MD – Doctor of Medicine	Administrative	Active	Forfeited	Relinquish
DO – Doctor of Osteopathic Medicine	Full	Applicant	General	Reprimand
DPM – Doctor of Podiatric Medicine	Limited	Cancelled	Inactive	Resident
DC – Doctor of Chiropractic	Military	Closed	Inst. Permit	Restricted
DDS – Doctor of Dental Surgery	Retired	Conditional	Invalid	Retired
DMD – Doctor of Dental Medicine	Special	Deceased	Lapsed	Revoked
EMT – Emergency Medical Technician	Supervising	Deleted	Limited	Surrender
LPN – Licensed Practical Nurse	Teaching	Delinquent	Military	Suspended
NP – Nurse Practitioner	Telemedicine	Denied	Non-Current	Temporary
PA – Physician Assistant	Temporary	Disabled	Non-Renew	Terminated
Psy.D. – Doctor of Psychology	Training	Exempt	Pending	Training
RN – Registered Nurse	Volunteer	Expired	Probation	Vocational
		Federal	Provisional	Withdrawn

1. State or province _____ Licensure board _____
 License number _____ Issue date _____ Expiration date _____
 Practitioner license type _____ License type _____ License status _____
(use above categories for this line)
2. State or province _____ Licensure board _____
 License number _____ Issue date _____ Expiration date _____
 Practitioner license type _____ License type _____ License status _____
3. State or province _____ Licensure board _____
 License number _____ Issue date _____ Expiration date _____
 Practitioner license type _____ License type _____ License status _____
4. State or province _____ Licensure board _____
 License number _____ Issue date _____ Expiration date _____
 Practitioner license type _____ License type _____ License status _____
5. State or province _____ Licensure board _____
 License number _____ Issue date _____ Expiration date _____
 Practitioner license type _____ License type _____ License status _____
6. State or province _____ Licensure board _____
 License number _____ Issue date _____ Expiration date _____
 Practitioner license type _____ License type _____ License status _____
7. State or province _____ Licensure board _____
 License number _____ Issue date _____ Expiration date _____
 Practitioner license type _____ License type _____ License status _____
8. State or province _____ Licensure board _____
 License number _____ Issue date _____ Expiration date _____
 Practitioner license type _____ License type _____ License status _____
9. State or province _____ Licensure board _____
 License number _____ Issue date _____ Expiration date _____
 Practitioner license type _____ License type _____ License status _____

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.

1. 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.
2. 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.
3. 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.
4. 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.

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 Primary Defendant
 Closed/settled Co-Defendant
 Dismissed (nothing paid) Other _____
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 Primary Defendant
 Closed/settled Co-Defendant
 Dismissed (nothing paid) Other _____
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 Primary Defendant
 Closed/settled Co-Defendant
 Dismissed (nothing paid) Other _____
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/> 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>.

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.ecfm.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.

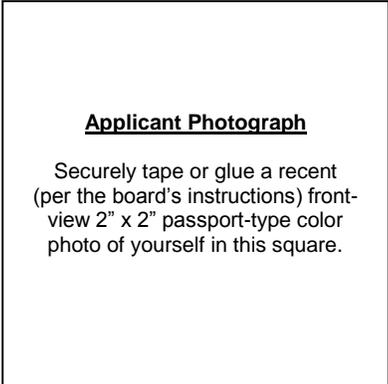
I acknowledge that I have read and understand the Uniform Application for Physician State Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being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

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 _____
 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.

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? **If yes**, indicate the reasons for each interruption or extension, the dates of each interruption or extension, and whether each interruption or extension was approved or unapproved. Yes No

- | | | | |
|---|---------------------|-----------------------------------|-------------------------------------|
| <input type="checkbox"/> Personal or family | From _____ to _____ | <input type="checkbox"/> Approved | <input type="checkbox"/> Unapproved |
| <input type="checkbox"/> Academic remediation | From _____ to _____ | <input type="checkbox"/> Approved | <input type="checkbox"/> Unapproved |
| <input type="checkbox"/> Health | From _____ to _____ | <input type="checkbox"/> Approved | <input type="checkbox"/> Unapproved |
| <input type="checkbox"/> Financial | From _____ to _____ | <input type="checkbox"/> Approved | <input type="checkbox"/> Unapproved |
| <input type="checkbox"/> Participation in a joint degree program | From _____ to _____ | <input type="checkbox"/> Approved | <input type="checkbox"/> Unapproved |
| <input type="checkbox"/> Participation in a non-research special study (e.g., fellowship, intl. experience) | From _____ to _____ | <input type="checkbox"/> Approved | <input type="checkbox"/> Unapproved |
| <input type="checkbox"/> Other _____ | From _____ to _____ | <input type="checkbox"/> Approved | <input type="checkbox"/> Unapproved |

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

<input type="checkbox"/> Academic	From _____ to _____	<input type="checkbox"/> Documentation attached
<input type="checkbox"/> Unprofessional conduct	From _____ to _____	<input type="checkbox"/> Documentation attached
<input type="checkbox"/> Behavioral reasons	From _____ to _____	<input type="checkbox"/> Documentation attached
<input type="checkbox"/> Other _____	From _____ to _____	<input type="checkbox"/> 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.

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

Signature _____
Print name _____
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.

Postgraduate Training Verification Form (Form #3)

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

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

Section 1: Applicant Information

First name _____ Last name _____ Practitioner Type DO
 Middle name _____ Suffix _____ SSN* _____ Birth date (mm/dd/yyyy) _____
 Name if different when diploma awarded _____
 Name of postgraduate training program _____

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

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

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

Applicant signature _____ Date _____

Section 2: Postgraduate Training Verification

Institution name _____ Affiliated school _____
 Institution address w/country _____
 Program year(s) _____ Attendance (mm/yyyy) from _____ to _____ Specialty _____
 Program type Internship Residency Internship/Residency
 Transitional Fellowship Fellowship/Research Other _____
 Training status Completed In Training Not Started Leave of Absence Withdrawn Dismissed
 Accredited by ACGME AOA APPAP CFPC LCGME RCPSC RSC None

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

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

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

Signature _____
 Print name _____
 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.

Fifth Pathway Verification Form (Form #4)

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

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

Section 1: Applicant Information

First name _____ Last name _____ Practitioner Type DO
 Middle name _____ Suffix _____ SSN* _____ Birth date (mm/dd/yyyy) _____
 Name if different when certificate awarded _____
 Name of medical school _____

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

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

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

Applicant signature _____ Date _____

Section 2: Fifth Pathway Verification

Institution name _____ Affiliated school _____
 Institution name if different when applicant attended _____
 Institution address w/country _____

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

Completed? Yes. Attendance was from _____ to _____. Completion date was _____.
 No. Withdrawal* date was _____. **If the applicant withdrew or was dismissed, please explain below.*
 No. Dismissal* date was _____. **If the applicant withdrew or was dismissed, please 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.

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

Signature _____
 Print name _____
 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.