OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION
P.O. BOX 18256
OKLAHOMA CITY, OK 73154-0256

APPLICATION FOR SPECIAL VOLUNTEER MEDICAL LICENSE

PRINT OR TYPE ANSWERS TO **ALL QUESTIONS** ON THIS FORM**.** IF NOT APPLICABLE, MUST PUT N/A.

LAST NAME:_____ MAILING ADDRESS:_____

FIRST NAME:_____ STREET / P.O. BOX:_____

MIDDLE NAME:_____ CITY:_____

SUFFIX: _____ SOC. SEC. NUMBER: _____ STATE:_____ZIP:_____

LICENSURE

LIST ALL JURISDICTIONS, INCLUDING OKLAHOMA (IF APPLICABLE), IN WHICH YOU ARE LICENSED OR IN WHICH YOU WERE PREVIOUSLY LICENSED:

_____

_____

PHOTOGRAPH

MOUNT PHOTOGRAPH HERE
IMPORTANT: AFFIX NOTARY SEAL PARTIALLY ON THE PHOTO AND PARTIALLY ON THE APPLICATION

THIS PHOTOGRAPH, TAKEN WITHIN THE PAST TWELVE MONTHS, IS A CORRECT LIKENESS OF MYSELF.

_____
APPLICANT SIGNATURE

_____
NOTARY SIGNATURE

COMMISSION NUMBER:_____ MY COMMISSION EXPIRES:_____

DO NOT WRITE BELOW THIS LINE - FOR OFFICE USE ONLY

APPLICATION RECEIVED_____ DATE APPROVED_____

COMMENTS:_____

MEDICAL SCHOOL:_____ CITY:_____

MO/YR ENTERED:_____/_____ _ MO/YR DEPARTED:_____/_____ STATE:_____COUNTRY:_____

PRACTICE HISTORY SINCE MEDICAL SCHOOL GRADUATION
ACCOUNT FOR ALL DATES IN CHRONOLOGICAL ORDER (INCLUDE MONTH AND YEAR)
(MAY ATTACH CV IN LIEU OF COMPLETING THIS SECTION)

FROM MO/YR	TO MO/YR	CITY	COUNTRY OR STATE	EMPLOYER OR PRACTICE SETTING (CLINIC, HOSP., SOLO PRAC., ETC.)	SPECIALTY OR ACTIVITY

ARE YOU FULLY RETIRED FROM THE PRACTICE OF MEDICINE? YES_____NO_____

HAVE YOU EVER SURRENDERED A LICENSE OR HAD A LICENSE REVOKED? YES_____NO_____

HAS ANY DISCIPLINARY ACTION BEEN TAKEN ON ANY LICENSE? YES_____ NO_____

HAVE YOU BEEN REQUESTED TO APPEAR BEFORE A LICENSING OR DISCIPLINARY AGENCY? YES_____NO_____

I, the undersigned, have fully read and understand the instructions. I swear or affirm that the information submitted in and with the application is, to the best of my knowledge, true and factual. I understand that attempts to deceive or fraudulently portray information contained herein may result in cancellation of my application or charges of filing a fraudulent application that may result in subsequent revocation of licensure.

_____ _____
Signature of Applicant Date

_____
Name of Applicant (type or print)

Please return your application to:

OSBMLS
PO Box 18256
Oklahoma City, OK 73154-0256

or

OSBMLS
101 NE 51st Street
Oklahoma City, OK 73105

OKLAHOMA STATE BOARD OF
MEDICAL LICENSURE & SUPERVISION
P. O. BOX 18256, OKLAHOMA CITY, OK 73154-0256
(405) 962-1400
e-mail: licensing@okmedicalboard.org

Volunteer Practice Setting Information

(Please print or type)

NAME OF PHYSICIAN:_____

Mailing Address: _____

_____

Volunteer Practice Location:___Remote Area Medical mobile clinic — Oklahoma State Fair Park / July 9 – 11_____
Name of Facility

_____Travel & Transportation Building, 333 Gordon Cooper Blvd._____
Address

____Oklahoma City_____OK_____73107_____(405) 410-5411_____
City State Zip Code Telephone Number

I hereby certify under oath that in accordance with Title 59 O.S., §493.5, the services being provided at the facility listed above are for the sole treatment of indigent and needy persons or persons in a medically underserved area and the services are being provided without the expectation of receiving any payment or compensation. Additionally, I understand that I may not practice at this facility until authorization from the Board is received; and, if I desire to change facilities that I must obtain prior approval from the Board.

_____
Signature of Physician

Sworn to before me this date:_____

_____
Notary Public

(SEAL)

Commission Number:_____ My commission expires:_____