



Please Note:

Pages 1-14 are for Physician Medical Licensure only. Pages 15-19 are for Physician Assistants Only.



Oklahoma State Board of Medical Licensure and Supervision
101 NE 51st St.
Oklahoma City, OK 73105-1821
Main Number: (405) 962-1400 Ext. 170
Fax: (405) 962-1440

Instructions for Applying for Physician Medical Licensure

Oklahoma State Board of Medical Licensure and Supervision

Instructions for Applying for Licensure/Examination/Reinstatement

The information contained herein is vital to the successful completion of your application and timely consideration of your request for licensure/reinstatement. Questions or challenges regarding application requirements should be addressed in writing to the Board Secretary. Lengthy telephone conversations with staff delay the overall ability to process applications. You will be notified that your application has been received by the Board Office and of all deficiencies in the application you submitted. You will also be notified how to check the status of your application on our web site: <http://www.okmedicalboard.org/>. The instructions are for your benefit, designed to reduce the need for requests for information after your application has been submitted. Once your application is complete, Board action can be expected within thirty (30) days.

Definitions

“**Act**” means the Oklahoma Allopathic Medical and Surgical Licensure and Supervision Act, 59 O.S. Section 480 et seq.

“**APA**” means either or both Article I and Article II, as applicable, of the Administrative Procedures Act, 75 O.S. 1991, Section 250 et seq., as amended.

“**Applicant**” means a person who applies for licensure from the Board.

“**Board**” means the Oklahoma State Board of Medical Licensure and Supervision.

“**Foreign applicant**” means an applicant who is a graduate of a foreign medical school.

“**Foreign medical school**” means a medical school located outside of the United States.

“**Secretary**” means the Secretary of the Board.

A. Options

Applications for licensure may be based on:

1. Endorsement of a current license held in any other state of the United States, Territory of the United States, District of Columbia, or Canada; or
2. Examination.

B. Reinstatement

An applicant for reinstatement shall meet all requirements in effect at the time reinstatement is requested. Upon receipt of your application and fee, you will be notified in writing what documentation is required to complete your application.

C. Temporary Licensure

The Board may authorize the Secretary to issue a Temporary Medical License for the intervals between Board meetings. Such Temporary License shall be granted only when the Secretary is satisfied as to the qualifications of the applicant to be licensed under this Act but where such qualifications have not been verified to the Board. Such a license shall:

1. Be granted only to an applicant demonstrably qualified for a full and unrestricted medical license;
2. Automatically terminate on the date of the next Board meeting at which the applicant may be considered for a full and unrestricted medical license.

An application for Temporary Licensure must be made by written request and include all appropriate fees.

C. Fees

1. All fees are non-refundable.
2. Fees must be paid online as part of the online application process. Fees returned by the payer’s financial institution must be replaced by a certified check or money order and include a \$30 returned check processing fee.

Medical License Fee	\$500
Temporary License Fee	\$250
First Year Post-Graduate Training License Fee	\$250
Reprocessing Fee	\$125

D. Examinations

1. Applicants who took the FLEX prior to June 1985 must have passed the examination with a FLEX weighted average of 75 or higher attained in one sitting. Scores that have been "factored" or scores from parts of the examination taken in separate sittings combined to achieve a 75 FLEX weighted average are not acceptable. Scores "rounded off" to achieve a 75 FLEX weighted average are not acceptable.
2. Scores achieved in the two-component FLEX examination must be 75 or higher in each component. Components may have been taken in separate jurisdictions or at separate sittings.
3. The Board will accept the following combinations of the USMLE, NBME, and FLEX examinations:
 - a. NBME Part 1 **or** USMLE Step 1 **plus**
NBME Part 2 **or** USMLE Step 2 **plus**
NBME Part 3 **or** USMLE Step 3;
 - b. FLEX Component 1 **plus** USMLE Step 3; **or**
 - c. NBME Part 1 **or** USMLE Step 1 **plus**
NBME Part 2 **or** USMLE Step 2 **plus** FLEX Component 2.
4. All steps of the licensure examination must be passed within ten (10) years.
5. If using the USMLE examination as the required licensure examination, in order to be eligible for a training license, all applicants must have passed USMLE Step 1 and Step 2. All applicants with a medical school graduation date in 2005 or later must pass USMLE Step 1 **and** USMLE Step 2 Clinical Skills (CS) **and** USMLE Step 2 Clinical Knowledge (CK). Additionally, those with a graduation date prior to 2005 who have not passed the Step 2 CK taken on or before June 30, 2005 must pass the Step 2 CS. When applying for a full, unrestricted medical license, an individual must pass Step 3 in addition to the requirements listed previously.
6. Any applicant who fails any part of a licensing examination three times is not eligible for a license. A score of incomplete is considered a failing score. If a combination of NBME, FLEX and/or USMLE is utilized, any applicant who has failed more than six (6) examinations is not eligible for a license. If an applicant has achieved certification by an American Board of Medical Specialties (ABMS) Board, the Board **may** grant an exception.
7. All applicants for initial licensure as a physician and surgeon in Oklahoma shall take and pass with a score of at least 75% a written examination covering medical jurisprudence. The examination shall specifically include, but not be limited to, the Oklahoma Medical Practice Act; Oklahoma Administrative Code; the prescribing, administering and dispensing of medications and controlled dangerous substances; pharmacy law; and licensure procedures. In the event of three failures, the applicant must meet with the Board Secretary in order to devise a study plan prior to taking the examination again.

NOTE: We must be in receipt of your exam scores in order for the Board Secretary to consider issuing a Temporary License.

E. Application Requirements

1. Each applicant shall have satisfactorily completed progressive postgraduate training approved by the Board. Graduates of medical schools in the United States shall have twelve (12) months of progressive post-graduate training. Applicants from a foreign medical school shall provide the Board with proof of successful completion of twenty-four (24) months progressive post-graduate medical training, obtained in the same medical specialty, from a program approved by:
 - a. The American Council on Graduate Medical Education (ACGME);
 - b. The Royal College of Physicians and Surgeons of Canada;
 - c. The College of Family Physicians of Canada;

- d. The Royal College of Physicians of Edinburgh;
 - e. The Royal College of Physicians of England;
 - f. The Royal College of Physicians and Surgeons of Glasgow; or
 - g. The Royal College of Surgeons in Ireland.
2. Graduates of foreign medical schools must submit a tape-recorded reading of a written selection created by the Board and evaluated by the Secretary as to the ability of the applicant to communicate in the English language or take an oral examination as determined by the Board. Additional information will be sent upon receipt of application.
 3. Applicants for licensure will be required to request an Extended Background Check (EBC) by completing the online EBC Authorization Form.
 4. All sections of the online Uniform Application for Physician State Licensure, including forms and state addenda, must be completed to the best of your knowledge. See G. Uniform Application Core Instructions for guidance.
 5. All education, training, and examination must be verified. You may use the Federation Credentials Verification Service (FCVS) for verifying your credentials, or you may verify your credentials on your own.
 - a. FCVS requires a one-time submission of identification, education, and training documents from primary sources for verification. Once this has been done and your permanent physician Profile is established, your information is securely stored by the Federation of State Medical Boards (FSMB). Your Profile can be sent to other licensing boards and health care entities at any time in the future, provided it is up to date and each board or entity is designated to receive it. To begin your Initial (First Time) or Subsequent (Update) FCVS Application, visit <http://www.fsmb.org/licensure/fcvs/> and sign in.
 - b. If you choose to verify your credentials on your own, you must submit the following to the Board:
 - i. Pre-Medical School. Official transcripts from all educational institutions attended (after high school) must be submitted in a sealed envelope directly from the institution.
 - ii. Medical School. Graduation from medical school must be verified by submitting the **Medical School Verification form** in the Uniform Application. More information can be found in section G, number 5 of these instructions.
 - iii. Post-Graduate Training. All completed training must be verified by submitting the **Postgraduate Training Verification form** in the Uniform Application. More information can be found in section G, number 5 of these instructions. Applicants for a special license to begin postgraduate training must have their prospective program complete this form to verify acceptance into the program.
 - iv. English Proficiency Examination (Foreign Medical School Graduates). Graduates of foreign medical schools must submit a tape-recorded reading of a written selection created by the Board and evaluated by the Secretary as to the ability of the applicant to communicate in the English language or take an oral examination as determined by the Board. Examination will be sent upon receipt of application.
 - v. Translations (Foreign Medical School Graduates). Graduates of foreign medical schools whose documents are not printed in the English language shall provide original translations. United States Consulates and formal foreign language education programs accredited by the North Central Association of Colleges and Schools are approved to provide translations to the Board. An applicant may request to use another translator. Such a request must be made in writing and include the proposed translator's name, address, and qualifications to support the approval of the request. Both the applicant and the translator shall attest to the accuracy of the translation.
 - vi. ECFMG Verification (Foreign Medical School Graduates). Graduates of foreign medical schools must provide verification of ECFMG certification. More information can be found in section G, number 2 of these instructions.
 - vii. Clerkships (Foreign Medical School Graduates). Effective January 1, 2004, an applicant that graduated from a foreign medical school after July 1, 2003 who completed clerkships in the United States, its territories or possessions, must have done the clerkships in hospitals or schools that have

programs accredited by the Accreditation Council for Graduate Medical Education (ACGME). A foreign medical school graduate who did clerkships in the United States must provide documentation regarding the clerkships. Every clerkship must be verified by submitted a completed *Verification of Clinical Clerkship form* (see addenda; signed by the program director or instructor and impressed with the institution's seal).

- viii. Licensing Examinations. Applicants must request that test scores be submitted to the Board directly from the Federation of State Medical Boards or the National Board of Medical Examiners, depending on the type of examination taken. More information can be found in section G, number 2 of these instructions.

F. General Application Process

This office may contact other sources for verification of information contained in your application. Your application will not be considered complete until the EBC and all other requests for verification have been received.

Once complete, applications are circularized to Board members for consideration. If all Board members approve the application, a license may be issued. Should one or more Board member fail to approve on circularization, the application will be reviewed during the next regularly scheduled business meeting of the Board. Applications are not denied on circularization. The applicant will be notified if the application has been held and given the opportunity to meet with the Board to discuss his/her application.

Even though an application is complete and all requirements are satisfied, there is no guarantee that the Board will grant licensure. The Board may find exceptions or make discoveries that will cause them not to approve an application. In such an event, the Board will clearly state the basis upon which such exceptions have been made. The Board may, at its discretion, require further proof of clinical competency.

There is no way to determine how soon you will receive notification of a Board decision after you submit an application. Even though we feel the instructions are thorough, should you have questions, you may contact the Licensing Department at (405) 848-6841. For questions about the Uniform Application, see G. Uniform Application Core Instructions for guidance.

Please utilize the checklist provided at the end of these instructions to ensure you have submitted each required item.

G. Uniform Application Core Instructions

Please read the following information carefully before completing your application. You will be asked to account for all time since medical school graduation, including providing your employment history, and asked to provide any information on medical malpractice claims. We recommend having this information on hand before you begin working on your UA.

The UA FAQ at <https://www.fsmb.org/licensure/uniform-application/faq> answers the most common UA questions. If your question or issue isn't listed, contact UA customer service at 800-793-7939 or email ua@fsmb.org. Provide your username and FCVS ID number if applicable. If you receive an error, email a screenshot of the error along with a description of what you were doing at the time to ua@fsmb.org.

Please note the following:

- Provide both your current home address and current practice/training address, otherwise an error will occur. Do not enter the same address for both home and work.
- MD and DO licenses cannot be added or edited in the UA as all MD and DO license information comes directly into the system from the state boards. Email ua@fsmb.org with the correct information if changes are needed.
- Enter all other professional licenses (nurse, EMT, physician assistant, etc.) you have held (active or inactive) in the U.S. or Canada. Request verification from these boards as well.
- If you hold licenses in countries outside the U.S. or Canada, please provide that information on a separate sheet of paper to the Board.
- If you have military or locum tenens assignments, you must list each location/assignment separately.

- Clinical time indicates time spent with patients. Administrative indicates time spent on paperwork.
- To open an already submitted UA for editing, select the Board from the State Board section. Update your UA as needed, then submit your UA to the Board.

In addition to completing the core UA online, all applicants must:

- Submit a notarized UA Affidavit and Authorization for Release of Information form to the Board. The UA Affidavit is separate from the FCVS Affidavit and must be sent to the Board, not to FCVS or FSMB. Attach a recent (fewer than 90 days old) two inch by two inch (2" x 2") passport quality, color photograph of yourself in the space provided.
- Have each full, temporary, training, or limited healthcare or profession license or certification you have ever held in the U.S. or Canada verified by the granting board, whether active or inactive. Determine the fees and preferred verification method for each medical board using the resource at <http://www.fsmb.org/licensure/uniform-application/>.
- Use the UA Licensure Verification Form for boards that need a written request. If the verifying board uses VeriDoc or another method, use VeriDoc or the preferred method instead of using the UA form.

If you are using FCVS for credentials verification,

- Do not complete the UA Medical Education Verification, Postgraduate Training Verification, or Fifth Pathway Verification forms. Do not send any identity documents, transcripts, certificates, or examination scores to the Board. FCVS handles all of this for you.

If you are **not** using FCVS for credentials verification,

- Send to the Board a certified copy of a legal name change document (marriage certificate, divorce decree, court order) if your name is not the same on all of your submitted documents.
- Contact each appropriate examination entity to have a certified transcript of your scores sent directly from the exam entity to the Board. If you have taken any component of the NBME in conjunction with another exam (USMLE/FLEX), request your transcript of scores from the NBME. For exam entity contact information, see the UA FAQ at <http://www.fsmb.org/licensure/uniform-application/faq>.
- Complete the UA Medical Education Verification, Postgraduate Training Verification, and Fifth Pathway Verification (if applicable) forms as directed on each form. The UA Medical School Verification form should be accompanied by a copy of your diploma if you graduated from that school. A certified transcript must be sent to the Board from the appropriate educational institution. If your transcript or any other document submitted is in a language other than English, also provide a certified translation.
- If you are an International Medical Graduate, request from ECFMG that your ECFMG certificate, Fifth Pathway Program Certificate, and/or FMGEMS certificate be sent to the Board, as applicable. See the UA FAQ at the link above for contact information.

H. State Specific Requirements

In lieu of a Uniform Application addendum, you will need to visit the Board's website and complete the state specific requirements at <https://www.ok.gov/medlic/licensing/app/login.php>.

- You must create a login to the Board's online application system either before or after submitting your Uniform Application through FSMB.
- Once you have logged into the Board's website, you will be asked to provide a Submit ID or Application ID. Do not use your Federation ID or FCVS ID. The Application ID is found within the confirmation email you receive after submitting the Uniform Application. If the Uniform Application is resubmitted, a new ID will be generated.
- Entering your Application ID will import your information from the UA into the Oklahoma application.

- You may then complete the additional requirements for Oklahoma, after which you will receive an individualized email with further instructions for monitoring the progress of your application.

For questions about the application process or the status of your application, contact the Oklahoma State Board of Medical Licensure and Supervision at 405-962-1400 ext. 112 (after hours 405-962-1400 ext 118).

Uniform Application for Physician State Licensure Checklist

Please use the column that applies to you. If you are using FCVS, you will be responsible for providing or requesting the information for each item not automatically completed by FCVS.

	Not Using FCVS	Using FCVS
Submitted the online Uniform Application and used the Application ID to complete the Oklahoma online application.	<input type="checkbox"/>	<input type="checkbox"/>
Requested licensure verification with each board that has granted you any healthcare or professional license.	<input type="checkbox"/>	<input type="checkbox"/>
Sent the following to the Oklahoma State Board of Medical Licensure and Supervision: - Fees - Notarized UA Affidavit and Authorization form - Translations of documents not in the English language (foreign medical graduates only) - English Proficiency Examination (foreign medical graduates only; will be provided upon receipt of application)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Sent notarized copy of birth certificate or current, valid passport to the Oklahoma State Board of Medical Licensure and Supervision.	<input type="checkbox"/>	Completed via FCVS
Sent supporting documentation of any legal name change (marriage certificate, divorce decree, or court document) to the Oklahoma State Board of Medical Licensure and Supervision.	<input type="checkbox"/>	Completed via FCVS
Sent a copy of your postgraduate training certificate(s) to the Oklahoma State Board of Medical Licensure and Supervision.	<input type="checkbox"/>	Completed via FCVS
Sent all examination transcripts to the Oklahoma State Board of Medical Licensure and Supervision.	<input type="checkbox"/>	Completed via FCVS
Sent the UA Medical School Verification form and a copy of your diploma to each medical school attended.	<input type="checkbox"/>	Completed via FCVS
Sent the UA Postgraduate Training Verification form to all training programs attended.	<input type="checkbox"/>	Completed via FCVS
Sent UA Fifth Pathway Verification form (Form #4) to the program director at the medical school/institution, if applicable. This is for physicians who went through a Fifth Pathway program only.	<input type="checkbox"/>	Completed via FCVS
Sent ECFMG certificate to the Oklahoma State Board of Medical Licensure and Supervision, if applicable. This is for foreign medical school graduates only.	<input type="checkbox"/>	Completed via FCVS



Affidavit and Authorization for Release of Information

Mail this completed notarized form to:

Oklahoma State Board of Medical Licensure and Supervision
P.O. Box 18256; Oklahoma City, OK 73154-0256

Applicant:

Sign this form with attached photo in the presence of a notary public. Send this notarized form with any other required materials to the Board at the address listed above.

If you are using FCVS for credentials verification, you must also send the separate FCVS affidavit form to FCVS if you have not already done so.

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 this square.

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)

-fold up-

To fit this form in a standard envelope, fold the bottom portion under the photograph toward the top, and then fold the top edge to the new bottom edge.

-fold up-

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 Form

Applicant: Complete this form as directed in the left sidebar.

Licensing Board: Complete this form as directed. Send the completed verification to the Oklahoma State Board of Medical Licensure and Supervision

Applicant:

Send this form and any applicable fee to each board you have held a full, temporary, training, or limited license with that requires a written request for license verification.

To determine each board's fees and licensure verification requirements, see <http://www.fsmb.org/licensure/uniform-application/>.

Section 1: Applicant Information

Last name: _____ Suffix: _____ Degree Type: M.D. D.O.

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 Medical Licensure and Supervision

Mailing address: P.O. Box 18256

City/State/Zip: Oklahoma City, OK 73154-0256

Applicant signature: _____ **Date:** _____

Licensing Board:

Complete section 2. Send this form to the board listed in section 1.

You may instead provide electronic licensure verification to the board listed in section 1.

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.

AFFIX BOARD SEAL HERE

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

Signature: _____

Print name: _____

Title: _____

Date: _____

Email: _____



Medical School Verification Form

Applicant: Complete this form as directed in the left sidebar.

Medical School: Complete this form as directed. Send the completed verification to the Oklahoma State Board of Medical Licensure and Supervision.

Applicant:

Complete section 1.

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

Copy this form for multiple schools.

If you are using FCVS for credentials verification, do not complete this form. FCVS handles this verification for you.

Section 1: Applicant Information

Last name: _____ Suffix: _____ Degree Type: M.D. D.O.

First name: _____ Middle name: _____

Date of Birth: _____ Social Security Number*: _____

Name if different when diploma 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 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 copy, and a copy of my official transcripts to the Board listed below at the given address.

Board name: Oklahoma State Board of Medical Licensure and Supervision

Mailing address: P.O. Box 18256

City/State/Zip: Oklahoma City, OK 73154-0256

Applicant signature: _____ **Date:** _____

Dean or Designated Official:

Complete section 2 and certify the enclosed copy of the applicant's diploma by placing your school seal on it.

Send the sealed diploma copy and an official copy of the applicant's transcripts with this completed form and any other materials to the board listed in section 1.

DO NOT send this form to FCVS or FSMB. Doing so will delay the applicant's licensure process.

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.

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 Form

Applicant: Complete this form as directed in the left sidebar.

Training Program: Complete this form as directed. Send the completed verification to the Oklahoma State Board of Medical Licensure and Supervision.

Applicant:

Complete section 1.

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

Copy this form for multiple training programs.

If you are using FCVS for credentials verification, do not complete this form. FCVS handles this verification for you.

Section 1: Applicant Information

Last name: _____ Suffix: _____ Degree Type: M.D. D.O.

First name: _____ Middle name: _____

Date of Birth: _____ Social Security Number*: _____

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 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 a 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 Medical Licensure and Supervision

Mailing address: P.O. Box 18256

City/State/Zip: Oklahoma City, OK 73154-0256

Applicant signature: _____ **Date:** _____

Dean or Designated Official:

Complete section 2. Report incomplete years separately from completed years. Report each Internship, Residency, and Fellowship separately.

Use one section for each specialty/sub-specialty. Provide a schedule of rotations if the specialty/sub-specialty is rotating/transitional.

Send this to the board listed in section 1 with any added materials, if applicable.

DO NOT send this form to FCVS or FSMB. Doing so will delay the applicant's licensure process.

Section 2: Postgraduate Training Verification

Institution name: _____

Institution street address: _____

Institution city / state or province / zip code: _____

Affiliated medical school name: _____

Institution / school name if different when the applicant attended: _____

1. Postgraduate year (e.g., 1, 2, 3, etc.): ____ Attendance dates: From _____ to _____
(mm/yyyy) (mm/yyyy)

Internship Residency Fellowship Research
 Chief Residency Unspecified Other: _____

Specialty/Subspecialty: _____

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

**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 APPAP CFPC
 LCGME RCPC RSC None of these

2. Postgraduate year (e.g., 1, 2, 3, etc.): ____ Attendance dates: From _____ to _____
(mm/yyyy) (mm/yyyy)

Internship Residency Fellowship Research
 Chief Residency Unspecified Other: _____

Specialty/Subspecialty: _____

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

**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 APPAP CFPC
 LCGME RCPSC RSC None of these

3. Postgraduate year (e.g., 1, 2, 3, etc.): ____ Attendance dates: From _____ to _____
(mm/yyyy) (mm/yyyy)

Internship Residency Fellowship Research
 Chief Residency Unspecified Other: _____

Specialty/Subspecialty: _____

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

**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 APPAP CFPC
 LCGME RCPSC RSC None of these

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: _____

AFFIX INSTITUTIONAL SEAL HERE

Title: _____

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

Date: _____

Phone number: _____ Fax number: _____

Email: _____



Fifth Pathway Verification Form

Applicant: Complete this form as directed in the left sidebar.

Program Director: Complete this form as directed. Send the completed verification to the Oklahoma State Board of Medical Licensure and Supervision.

Applicant:

Complete section 1. Legibly enter your name at the bottom of both pages.

Send this form to your Fifth Pathway director.

If you are using FCVS for credentials verification, do not complete this form. FCVS handles this verification for you.

Section 1: Applicant Information

Last name: _____ Suffix: _____ Degree Type: M.D. D.O.

First name: _____ Middle name: _____

Date of Birth: _____ Social Security Number*: _____

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 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 a 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 Medical Licensure and Supervision

Mailing address: P.O. Box 18256

City/State/Zip: Oklahoma City, OK 73154-0256

Applicant signature: _____ **Date:** _____

Program Director or Designated Official:

Complete section 2.

Send this to the board in section 1 with any added documentation, if applicable.

DO NOT send this form to FCVS or FSMB. Doing so will delay the applicant's licensure process.

Section 2: Fifth Pathway Verification

Institution name: _____

Institution street 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.

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: _____



Oklahoma State Board of Medical Licensure and Supervision
101 NE 51st St.
Oklahoma City, OK 73105-1821
Main Number: (405) 962-1400 Ext. 170
Fax: (405) 962-1440

Instructions for Applying for Physician Assistant (PA) Licensure

A. Application for Licensure as a PA

1. A Physician Assistant (PA) may be considered for licensure if he/she meets the following qualifications:
 - (a) Possesses good moral character, and
 - (b) Graduated from an accredited PA program consisting of the at least one year of classroom instruction and one year of clinical experience that included a minimum of one month each in family medicine, emergency medicine and surgery, and
 - (c) Has passed an examination for physician assistants recognized by the Board.
2. All required documents, forms and fees must accompany each application before it will be presented to the Physician Assistant Advisory Committee.

B. Application to practice as a PA

A PA may not perform any health care services until the supervising physician and PA jointly file a current application to practice and a letter authorizing practice to begin is approved. Applicants to practice received between meetings of the Committee will be reviewed by the Secretary of the Board who may grant permission by the letter to practice temporarily until the next meeting of the Committee and the Board.

C. Application and forms for licensure as a PA

1. All sections of the on-line application must be completed to the best of your knowledge.
2. The photo attached to the application **MUST** show the notary seal impressed partially on the photograph and partially on the application to ensure that the photo on the application was the same photo notarized. Photo must be firmly affixed to the application and must not exceed the space provided, nor obscure other information on the application.
3. Any YES answers to the questions **MUST** be explained in a statement, signed by the applicant, and notarized. If you answered "Yes" too any of the questions regarding previous arrests you must additionally submit copies of all police reports/court records. If you have previously obtained an assessment and/or been treated for the use of any drugs or chemical substance (including alcohol), please submit copies of the assessment and treatment records.
4. All education and examination must be verified.
Graduation from an accredited PA program may be verified on FORM #1 to which a certified copy of the diploma is attached. Applicants must also submit a transcript of grades issued by the school. The National Commission of the Certification of Physician Assistants (NCCPA) must verify successful completion of the national certifying examination for physician assistants. In lieu of contacting your school and NCCPA, you may contact the Federation Credentials Verification Service (FCVS) and obtain the appropriate application and forms for them to verify your information (FCVS, 400 Fuller Wisser Rd. Suite 300. Euless, TX 76039. Phone: 817-868-4000).
5. Evidence of all current or previously issued licenses or certificates or certificate to practice as a PA must be verified on form #3 by the licensing jurisdiction granting the license/certificate.

D. Application and forms to practice as a PA

1. The Primary Supervising Physician and PA must jointly complete and sign form #5, Application Practice.
2. Each alternate supervising must submit form #6. Alternate supervising physician may exercise their responsibility in the absence of the primary supervising physician and may utilize the PA only in the coverage of the primary supervising physician's practice.

E. General Information

1. Physician may supervise 4 PA's except: (A) The medical director of a state institution may supervise more than 4 PA's; and (B) A physician may request approval for more than 4 PA's in the clinical aspect by presentation of the application to practice to the Physician Assistant Advisory Committee in meeting.
2. Enclosed for your information are guidelines prepared by the Board of Medical Licensure and Supervision that explain more fully the Board's position on the PA utilization.

Additional PA Application Instructions

F. Extended Background Check

All applicants for licensure are required to request an **Extended Background Check** (EBC) by completing the online EBC Authorization Form.

G. Change In Practice Locations or Supervising Physicians

1. Any change in practice locations or primary supervising must be approved by the Board upon submission of a properly completed supplication to practice for each change.
2. Material previously submitted for the original application to practice will be reviewed and those documents already on file and verified will be transferred to the request.

H. Fees (All Fees Are Non-Refundable)

Current

- | | |
|--|--|
| 1. Initial Licensure Fee | \$150.00 (Paid on line – Do not resubmit) |
| 2. Application to Practice Fee | \$ 50.00 (Included with initial licensure fee for first time applicants) |
| 3. Renewal Fee | \$125.00 |
| 4. Renewal/Late Fee (between April 1 and May 31) | \$225.00 |

I. Renewals:

1. Licenses are renewed annually by application PRIOR to March 31st of the subsequent year beginning April 1 and the ending the last day of March. Licenses Issued BEFORE March 31 must be renewed for the next occurring renewal period most immediately subsequent to the date of issue of the license.
2. Following initial licensure, each PA must provide evidence that he or she has successfully completed 20 hours of Category 1 approved continuing medical education each year. The CME hours shall be logged and reported to the Board on an annual basis by the Oklahoma Academy of Physician Assistants, Inc. The PA shall bear the cost of this requirement.
3. Unrenowned licenses become inactive as of April 1 and if reactivated on or after April 1, a late payment fee is assessed in addition to the renewal fee.
4. If a license is not renewed by May 31, the PA will be required to submit a new application for licensure and a new application to practice, and pay the initial licensure fees.

PRACTICE MAY NOT BEGIN UNTIL APPROVED BY THE STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION. TO FACILITATE THE APPLICATION AND RENEWAL PROCESS, KEEP THIS OFFICE INFORMED OF YOUR CURRENT ADDRESS AT ALL TIMES.

I, the undersigned, have read the instructions and understand their content. I swear/affirm the contents of my application are true. All information supplied by application may be verified by the Oklahoma State Medical Licensure and Supervision. I have read and understand the Physician Assistant Act that I received with my application.

Printed Name

Date

Signature

Additional Information

Please click on the links below to download the appropriate forms.

Link	Allied Professionals Registration Click on the link to the left to fill out your Application for licensure Online. <i>This is for New Licenses and Reinstatements only.</i> A PDF containing the instructions may be downloaded below
Link	Evidence of Status Form - New legislation took effect November 1, 2007, requiring the Board of Medical Licensure and Supervision to issue a license only to U.S. citizens, nationals and legal permanent resident aliens; and to applicants who present valid documentary evidence of: A valid, unexpired immigrant or nonimmigrant visa status for admission into the U.S.; A pending or approved application for asylum in the U.S.; Admission into the U.S. in refugee status; A pending or approved application for temporary protected status in the U.S.; Approved deferred action status; or A pending application for adjustment of status to legal permanent residence status or conditional resident status. Applicants in the above six categories will only be eligible to receive a license card that is valid for the time period of their authorized stay in the U.S., or if there is no date of end to the time period of their authorized stay, for one year. The information will be verified through the Systematic Alien Verification for Entitlements (SAVE) Program, operated by the U.S. Department of Homeland Security. In order to verify citizenship or qualified alien status, applicants for licensure by endorsement or examination or for reinstatement of their license, must submit an Evidence of Status Form and the required supporting documentation with their application.
Download	Oath and Photo Page - must accompany all new license applications. - revised February 26, 2017
Download	Form 1 - Allied Verification of Education - updated November 14, 2016
Download	Form 3 - Allied Verification of Licensure Certification
Download	Form 5 - Application to Practice as a Physician Assistant and Utilization Guidelines - revised April 18, 2017
Download	Form 6 - Alternate Supervising Physician - revised April 18, 2017
Link	Extended Background Check (EBC) Consent to Perform Criminal History Background Check in Compliance with the FCRA (Fair Credit Reporting Act)
Link	Application for Modification - submit this form for a Name Change on an existing license along with official documentation (copy of marriage license, divorce decree, etc) and fee.

Uniform Application PA Checklist for Licensure

Please use the column that applies to you. If you are using FCVS, you will be responsible for providing or requesting the information for each item not automatically completed by FCVS.

	Not Using FCVS	Using FCVS
Submitted the online Uniform Application and used the Application ID to complete the Oklahoma online application.	<input type="checkbox"/>	<input type="checkbox"/>
Requested licensure verification with each board that has granted you any healthcare or professional license, (Form # 3) .	<input type="checkbox"/>	<input type="checkbox"/>
Sent the following to the Oklahoma State Board of Medical Licensure and Supervision: - Fees - Notarized UA Affidavit and Authorization form - Application to Practice as a Physician Assistant and Utilization Guidelines, (Form # 5) .	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Extended Background Check (EBC) Consent to Perform Criminal History Background Check in Compliance with the FCRA (Fair Credit Reporting Act).	<input type="checkbox"/>	<input type="checkbox"/>
Oath and Photo Page Form.	<input type="checkbox"/>	<input type="checkbox"/>
Alternate Supervising Physician, (Form # 6) .	<input type="checkbox"/>	<input type="checkbox"/>
Sent notarized copy of birth certificate or current, valid passport to the Oklahoma State Board of Medical Licensure and Supervision.	<input type="checkbox"/>	Completed via FCVS
Sent supporting documentation of any legal name change (marriage certificate, divorce decree, or court document) to the Oklahoma State Board of Medical Licensure and Supervision.	<input type="checkbox"/>	Completed via FCVS
Sent all examination transcripts to the Oklahoma State Board of Medical Licensure and Supervision.	<input type="checkbox"/>	Completed via FCVS
Sent the Verification of Education, (Form # 1) .	<input type="checkbox"/>	Completed via FCVS
Sent the Postgraduate Training Verification form to all training programs attended. (If Applicable).	<input type="checkbox"/>	Completed via FCVS