FORM #4 (MD)

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

VERIFICATION OF CLINICAL CLERKSHIP

In the event a foreign medical school utilized clerkships in the United States, its territories or possessions, and the applicant graduated from medical school after July 1, 2003, such clerkships shall have been performed in hospitals and schools that have programs accredited by the Accreditation Council for Graduate Medical Education (ACGME).

One form must be completed and mailed directly to the Board for each clerkship.

This is to certify that_____; ____ ____ ____ / ____ ____ / ____ ____ ____ ____,
Student's Name U.S. Social Security Number

_____ a student of _____
Date of Birth Medical School

Completed a clerkship offered by _____
Name of Facility

_____
Address of Facility

From_____ through _____ in the clinical area
Month Day Year Month Day Year

Of_____.
Clinical Area

This facility has programs that are accredited by ACGME in the areas of _____.
Specialty

I, _____, swear or affirm that I am/was the individual facility program director or instructor for the student named above during the clerkship indicated and that I have carefully read and completed this form and that the statements made herein are accurate.

Institution
Seal

_____
Type or Print Name of Facility Program Director or Instructor

_____
Address

_____
City State Zip Code

_____ _____
Telephone Number Signature

In the absence of an official institution seal, the Facility Program Director or Instructor's signature must be notarized.

Signed and sworn before me this _____ day of _____(Month) _____(Year).

_____
Notary Public Signature

Notary
Seal

My Commission Expires:_____