RCFORM #1

OKLAHOMA STATE BOARD OF
MEDICAL LICENSURE AND SUPERVISION
P. O. BOX 18256, OKLAHOMA CITY, OK 73154-0256
(405) 962-1400

VERIFICATION OF EDUCATION

THIS ORIGINAL FORM MUST BE RECEIVED DIRECTLY FROM THE PROGRAM YOU ATTENDED

I,_____, DO HEREBY CERTIFY
Name of educator

THAT _____
Name of applicant

ATTENDED_____LOCATED IN _____
Name of institution City/State

TRAINING BEGAN ON _____/_____/_____ TRAINING ENDED ON _____/_____/_____

AWARDED DEGREE/CERTIFICATE OF_____

Records of this institution indicate that the applicant has been the subject of disciplinary action. ☐ **YES** ☐ **NO**
If applicant has been the subject of disciplinary action (i.e., suspension, probation, etc.) please explain on a separate sheet of paper
.

_____
Name of Educator

_____
Signature

SCHOOL
SEAL

_____
Title

_____
Date

If the school does not have a seal, please have the form notarized below.

Sworn to before me on: _____

My Commission expires:_____

(NOTARY SEAL)

Commission Number:_____

Notary Signature:_____