Oklahoma State Board of Osteopathic Examiners

MEMORANDUM

FROM: **Christi Aquino**
Director of Licensing

TO: **Licensure Applicants**

DATE: **January 1, 2026**

SUBJECT: **License Application Documents**

Dear Applicant:

This memo includes documents and links to assist you in completing your primary source requirements for licensure. For further questions, please call our office at (405) 528-8625 or send an email to licensing@osboe.ok.gov. **Note: If using FCVS, they will obtain the Post Graduate Training Verification, Medical School Verification, NBOME scores, and Data Bank on your behalf.**

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Medical School Verification- Pages 3-4

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NBOME Transcripts- If you have taken all three parts of the NBOME sequence, you will use this method of application as your basis for licensure. Please contact the National Board directly at (773) 714-0622 or visit www.nbome.org to request that a transcript of your grades be sent directly to the Oklahoma State Board of Osteopathic Examiners.

National Practitioner Data Bank Report- 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 or email the report to you. For questions or assistance, call (800) 767-6732 or email help@npdb.hrsa.gov.

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

For State Board Use Only

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	**5400 N. Grand Blvd., Suite 130**
City/State/Zip	**Oklahoma City, OK 73112**

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. Except, if a leave of absence or break from his/her training was taken related to treatment for a mental health, substance use disorder or physical condition, no further explanation is necessary. 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 _____

AFFIX INSTITUTIONAL SEAL HERE

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

Title_____Date_____

Phone number_____Fax number _____

Email _____

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

For State Board Use Only

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 or 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	**5400 N. Grand Blvd., Suite 130**
City/State/Zip	**Oklahoma City, OK 73112**

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 ☐

☐ Personal or family	From_____to_____	☐ Approved	☐ Unapproved
☐ Academic remediation	From_____to_____	☐ Approved	☐ Unapproved
☐ Financial	From_____to_____	☐ Approved	☐ Unapproved
☐ Participation in a joint degree program	From_____to_____	☐ Approved	☐ Unapproved
☐ Participation in a non-research special study (e.g., fellowship, intl. experience)	From_____to_____	☐ Approved	☐ Unapproved
☐ Other _____	From_____to_____	☐ Approved	☐ 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 ☐

☐ Academic	From_____to_____	☐ Documentation attached
☐ Unprofessional conduct	From_____to_____	☐ Documentation attached
☐ Behavioral reasons	From_____to_____	☐ Documentation attached
☐ Other _____	From_____to_____	☐ 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.

Signature _____
Print name _____
AFFIX INSTITUTIONAL SEAL HERE
(If no seal is available, this form must be notarized.)
Title_____Date _____
Phone number_____Fax number _____
Email _____

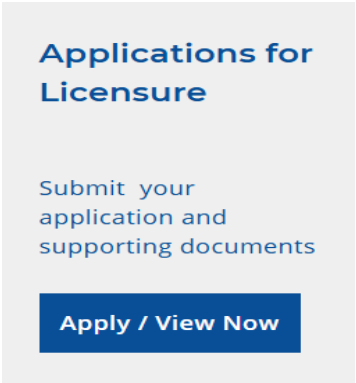
Please mail this completed form and any other items to the board at the address listed in Section 1. Thank you.

OSBOE Licensure Checklist for 2025-26
oklahoma.gov/osboe

Here is a checklist for OSBOE online license application.

1. **Medical School Verification ___(fill out Section 1 & mail to Med. School)**
2. **PGY 1 Verification ___(fill out Section 1 & give to Coordinator)**
3. **Residency Verification (PGY 2 – PGY 4) ___(fill out Section 1)**
4. **NBOME Scores ___(request online at www.nbome.org)**
5. **License Fee - $625 ___(pay with credit card online or send a check)**
6. **National Practitioner Data Bank ___(YOU can upload your report. Request online at (https://www.npdb.hrsa.gov/ext/selfquery/SQHome.jsp)**
7. **Birth Certificate/Passport ___(YOU get copied, notarized, and uploaded)**
8. **Background Check ___(YOU access the IdentoGO Fingerprinting link on app at (https://ok.ibtfingerprint.com/ with code 2B7QGR)**
9. **Passport Photo ___(YOU upload a 3x4 or larger online)**
10. **Licenses from other states (LPN, RN, EMT, etc…)**
11. **If you answer "YES" to any question, provide ALL documentation for this by uploading every document, including your explanation of events.**

Click on this tile on the front page of our website:



OR log in to your license portal and click on "Start Application" if you are currently licensed with a Resident Training license.

2025 Do's and Don’ts of Licensure

*****Directors and Coordinators, please give this to your new residents who are filling out the <u>full license</u> application.**

1. If you already have a Resident training license, **<u>DO NOT start a new account</u>** to apply for your full license. Log in with your email and password and click “Start Application.”

2. Know the application to start with. Use the “Uniform” application, not FCVS.

3. Do NOT autofill your application online.

4. Verify the name you would like on your application. I copy and paste the name you enter.

5. Do not upload photos from your phone. We cannot open them.

6. Do not send primary source documents like license verifications, medical school verifications, or postgraduate verifications.

7. Apply and submit as soon as possible. Do not wait for documents to come in.

8. Change your address before June 15th, or you will not receive your wall license. Preferably, put your parent or a friend in the “mailing” section for your address, and it will go there.

9. Don’t wait to receive documents to “submit” your application. Submit asap.

Reminder about COMLEX III—You must take your test by April 15th to get licensed on time to start your PGY 1. Your results will take two months to arrive. You cannot start your PGY 2 until the test is passed and ordered and I have received the results to upload. If you receive your passing results after July 1, 2026, order them from NBOME immediately to be sent to OSBOE.

***If you do not complete and submit your license app in time (by May 15, 2026), and the Board does not have all documentation by June 30, and the program believes you are ready to be promoted to be a PGY II, the sponsoring institution requires you be renewed without being promoted. This is a reviewable concern which will stay on your file and be reportable in the future.**

IdentoGO

OK State Board of Osteopathic Examiners

Fingerprint Service Code Form

Service Name: OK Board of Osteopathic Medicine, Licensing - Osteopathic Medicine Applicant

To schedule your fingerprint appointment, simply visit https://ok.ibtfingerprint.com and enter the following Service Code

2B7QGR

Service Code is unique to your hiring/licensing agency. Do not use this code for another purpose.

Please bring one of the identification documents from the list below to your enrollment appointment.

- Driver's License issued by a State or outlying possession of the U.S.
- Driver's License PERMIT issued by a State or outlying possession of the U.S.
- Driver's License PAPER/TEMPORARY issued by a State or outlying possession of the U.S.
- Enhanced Driver's License (EDL)
- Commercial Driver's License issued by a State or outlying possession of the U.S.
- Commercial Driver's License PERMIT issued by a State or outlying possession of the U.S
- ID card issued by a federal, state, or local government agency or by a Territory of the United States
- Enhanced Tribal Identification Card (for federally recognized U.S. tribes)
- Department of Defense Common Access Card
- Uniformed Services Identification Card (Form DD-1172-2)
- U.S. Military Identification Card
- U.S. Coastguard Merchant Mariner Card
- Military Dependent's Identification Card
- U.S. Passport
- Foreign passport
- Permanent Resident Card or Alien Registration Receipt Card (Form I-551)
- Employment Authorization Card/Document (I-766) that contains a photograph
- Canadian Driver's License
- Foreign Driver's License (Mexico and Canada Only)
- U.S. Visa issued by the U.S. Department of Consular Affairs for travel to or within, or residence within, the United States

Pre-License Application Questions

These are the questions that will be on the online application.

1. Have you ever been rejected for membership by or requested to appear before any medical or osteopathic society?
   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.

2. Have you ever been denied the privilege of taking an examination administered by any licensing board agency?
   If Yes, please provide the name of the examination and the agency's name on a separate sheet of paper.

3. Have you ever been denied a license to practice osteopathic medicine, withdrawn your application, or have had your application tabled?
   If Yes, please provide full details on a separate page. This must include the state(s), date(s), and reason(s).

4. Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, had privileges suspended, been put on probation from any medical school, training facility or program, medical practice, medical partnership, hospital, nursing home, clinic, professional association, corporation, health maintenance organization, other medical practice organization, or other hospital care facility, either public or private?
   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.

5. Have you ever been requested to resign, withdraw, or otherwise separate your position with a medical school, training facility or program, medical practice, medical partnership, hospital, nursing home, clinic, professional association, corporation, health maintenance organization, other medical practice organization, or other hospital care facility, either public or private?
   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.

6. Have you ever, for any reason, lost Board Certification in any specialty or had your status suspended or tabled?
   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.

7. Has any state or federal licensing authority or disciplinary agency, including but not limited to other state or federal licensure boards, limited, placed on probation or conditions, restricted, suspended, or revoked a license or permit you have held?

If Yes, give full details on a separate page. This should include the state(s), date(s), and reason(s).

8. Have you ever voluntarily surrendered a license to practice medicine, surrendered in lieu of an investigation or complaint, allowed it to expire or lapse, retired a license while under an investigation or complaint, lost hospital privileges, lost specialty board membership, or permit issued to you by any licensing agency or hospital?
   If Yes, give full details on a separate page. This should include the states, dates, and reasons.

9. Have you ever been requested to appear before any licensing board or disciplinary agency?
   If Yes, give full details on a separate page. This should include the state(s), date(s), and reason(s)

10. Have you ever been formally notified of any investigations, violations, or complaints against you with any licensing board or disciplinary agency?
    If Yes, give full details on a separate page. This should include the state(s), date(s), and reason(s).

11. Have you ever been denied a Drug Enforcement Administration (DEA) certificate or a state bureau of narcotics controlled substances registration certificate, been called before, or warned by any such agency or other lawful authority concerned with controlled substances?
    If Yes, provide full details in a separate notarized statement.

12. Has the Drug Enforcement Administration (DEA) or any state bureau of narcotics ever limited, placed on probation or conditions, restricted, suspended, or revoked a license or permit you have held?
    If Yes, provide full details, including dates, in a separate notarized statement.

13. Have you ever surrendered or had disciplinary action taken against your federal or state controlled substances registration?
    If Yes, provide full details, including dates, in a separate notarized statement.

14. Have you ever been arrested, fined, charged with, or convicted of a crime, received a deferred sentence, expungement, entered an Alford plea or nolo contendere, indicted, imprisoned, or placed on probation? All arrests, including all DUI/DWI arrests or convictions, shall be reported here.
    If Yes, give full details of the arrest, dates, places, and disposition in a separate notarized statement, even if the case was expunged. 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 do not need to include minor traffic and parking violations except those related to DUI, DWI, or a similar charge.

15. Have you ever forfeited collateral for breach or violation of any law, police regulation, or ordinance, been summoned into court as a defendant, or have any lawsuit (other than malpractice) been filed against you?
    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, state and have your attorney provide a letter regarding the case and its current status.

16. Have you ever been denied provider participation in any state Medicaid, federal Medicare program, or third-party payor?
    If Yes, give full details, including dates and the names and addresses of the Medicaid, Medicare program, or any other payor in a separate notarized statement. Furnish a letter addressed to each, authorizing them to release whatever information the Board may require.

17. Have you ever been terminated, sanctioned, penalized, settled, or had to repay monies to any state Medicaid, federal Medicare program, or any third-party payor?
    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.

18. Have you ever been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid on your behalf or paid such a claim yourself?
    If Yes, provide all information required within the Malpractice Liability Claims section of the Uniform Application.

19. Have you ever been reported to the National Practitioner Data Bank (NPDB)?
    If Yes, provide the data bank report and any documents pertaining to the incident, and provide a letter stating what occurred in your own words.

20. Have you engaged in illegal use or misuse of illicit drugs or prescription medications? It should be noted under Oklahoma Medical Marijuana law a safety sensitive position should not possess a medical marijuana card. Safety sensitive is defined in Title 63 O.S. 427.8(K) and includes direct patient care.
    If Yes, provide full details on a separate page.

21. Have you recent taken any prescription drug without the supervision of a licensed health care professional?
    If Yes, provide full details on a separate page.

22. Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical, and professional manner?
    If Yes, provide full details on a separate page.