



This request form is intended for use in obtaining the below documents. Please complete all fields before submitting. The second attachment is only required when requesting a license verification. You may mail this completed form to 5400 N. Grand Blvd., Suite 130, Oklahoma City, OK 73112 with a check for owed funds, or submit via email at [licensing@osboe.ok.gov](mailto:licensing@osboe.ok.gov) if you'd prefer to pay the invoice over the phone. **Note:** These forms are also available for order online in the physician's licensee dashboard.

**Date:** \_\_\_\_\_

**Requestor's Name:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Type of Request:**

- |   |                          |                |
|---|--------------------------|----------------|
| <b>License Verification</b><br>(For other licensing boards – complete attached) | <input type="checkbox"/> | <b>\$30.00</b> |
| <b>Letter of Good Standing</b><br>(Addressed to the Secretary of State)         | <input type="checkbox"/> | <b>\$30.00</b> |
| <b>Letter of Good Standing</b><br>(Credentialing, employer requests, etc.)      | <input type="checkbox"/> | <b>\$30.00</b> |
| <b>D.O. Licensure File</b>  | <input type="checkbox"/> | <b>\$50.00</b> |
| <b>D.O. Disciplinary File Only</b>  | <input type="checkbox"/> | <b>\$25.00</b> |
| <b>Physician Database</b>   | <input type="checkbox"/> | <b>\$50.00</b> |

**Request Concerning the Following:**

**License No.** \_\_\_\_\_

**Physicians Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_



Please enter the required information, sign, and date at the bottom. Include this form with the License Request Form and the required fee.

**Physician Last Name:** \_\_\_\_\_ **Physician First Name:** \_\_\_\_\_ **M.I.:** \_\_\_\_\_

**Other Names Used (if applicable):** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**License Issue Date:** \_\_\_\_\_

**License No.:** \_\_\_\_\_

**Verification Mailed**  **or** **Verification Emailed**

I, \_\_\_\_\_, hereby authorize and request the Oklahoma State Board of Osteopathic Examiners to provide information regarding my license including documents and/or records regarding disciplinary action against me or my license to:

\_\_\_\_\_  
Agency

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Email

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_