

**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 for 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	<b>Oklahoma State Board of Osteopathic Examiners</b>
Mailing address	<b>5400 N. Grand Blvd., Suite 130</b>
City/State/Zip	<b>Oklahoma City, OK 73112</b>

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.

- Personal or family
- Academic remediation
- Financial
- Participation in a joint degree program
- Participation in a non-research special
- study (e.g., fellowship, intl. experience)
- Other \_\_\_\_\_

From \_\_\_\_\_ to \_\_\_\_\_  
From \_\_\_\_\_ to \_\_\_\_\_  
From \_\_\_\_\_ to \_\_\_\_\_  
From \_\_\_\_\_ to \_\_\_\_\_  
From \_\_\_\_\_ to \_\_\_\_\_  
From \_\_\_\_\_ to \_\_\_\_\_

<input type="checkbox"/> Approved	<input type="checkbox"/> Unapproved
<input type="checkbox"/> Approved	<input type="checkbox"/> Unapproved
<input type="checkbox"/> Approved	<input type="checkbox"/> Unapproved
<input type="checkbox"/> Approved	<input type="checkbox"/> Unapproved
<input type="checkbox"/> Approved	<input type="checkbox"/> Unapproved
<input type="checkbox"/> Approved	<input type="checkbox"/> 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  
 Unprofessional conduct  
 Behavioral reasons  
 Other \_\_\_\_\_

From \_\_\_\_\_ to \_\_\_\_\_  
From \_\_\_\_\_ to \_\_\_\_\_  
From \_\_\_\_\_ to \_\_\_\_\_  
From \_\_\_\_\_ to \_\_\_\_\_

Documentation attached  
 Documentation attached  
 Documentation attached  
 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 \_\_\_\_\_

Title \_\_\_\_\_ Date \_\_\_\_\_

Phone number \_\_\_\_\_ Fax number \_\_\_\_\_

Email \_\_\_\_\_

AFFIX INSTITUTIONAL SEAL HERE  
(If no seal is available, this form must be notarized.)

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