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Training status ☐ Completed ☐ In Training ☐ Not Started ☐ Leave of Absence ☐ Withdrawn ☐ Dismissed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 _____