FORM #3 (Perfusion)

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

VERIFICATION OF LICENSURE/CERTIFICATION

THIS FORM MUST BE COMPLETED BY THE STATE REGULATORY AGENCY IN EACH STATE FROM WHICH YOU HOLD OR EVER HELD A LICENSE TO PRACTICE. THE SEAL OF THE AGENCY MUST BE IMPRESSED ON THIS FORM OR THE STATEMENT AT THE BOTTOM OF THIS FORM. MUST BE SIGNED BY THE AUTHOR AND THE SIGNATURE NOTARIZED. ALL SIGNATURES MUST BE ORIGINAL.

NAME OF APPLICANT_____ **LICENSE NUMBER** _____

PROFESSION IN WHICH LICENSE WAS ISSUED_____

NAME OF STATE ISSUING LICENSE_____

LICENSE ISSUED ON THE BASIS OF_____

DATE ISSUED _____ **CURRENT** _____ **NOT CURRENT** _____

IF NOT CURRENT, EXPLAIN BRIEFLY WHY NOT :

DATES OF DISCIPLINARY ACTION (if applicable) _____

REASON FOR DISCIPLINARY ACTION _____

_____
Name of official of agency

_____
Original Signature

_____
Title

_____
Date (mm/dd/yy)

(SEAL)