

FORM #2

**OKLAHOMA STATE BOARD OF PODIATRIC MEDICAL EXAMINERS  
P.O. BOX 18256, OKLAHOMA CITY, OK 73154-0256**

NAME OF APPLICANT \_\_\_\_\_  
(TYPE OR PRINT)

NAME OF INSTITUTION \_\_\_\_\_

\_\_\_\_\_  
CITY STATE

DATE ENTERED: \_\_\_\_/\_\_\_\_/\_\_\_\_ DATE COMPLETED: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MO DAY YR MO DAY YR

TYPE OF PROGRAM (check one):

APPROVED: PSR-12\_\_\_\_ or PSR-24\_\_\_\_ or PM&S-36\_\_\_\_

NON-APPROVED RESIDENCY:\_\_\_\_ CLERKSHIP:\_\_\_\_ OTHER\*:\_\_\_\_

\*If "OTHER" , give brief explanation:\_\_\_\_\_

A Certificate of Training was \_\_\_\_\_ was not \_\_\_\_\_ issued as proof of completion of said training. **Attached is a certified copy of the certificate issued.**

I, the applicant, do hereby swear or affirm that I have completed this program and satisfied all requirements of me.

\_\_\_\_\_  
(name of applicant - print or type)

\_\_\_\_\_  
(signature of applicant)

To my knowledge this applicant performed satisfactorily in this program and there was no disciplinary action outstanding or pending against this applicant. I know of no reason this individual should not be licensed to practice podiatry.

\_\_\_\_\_  
(name of program director - print or type)

INSTITUTION

SEAL

\_\_\_\_\_  
(signature of program director)

I have information that should be reviewed by the licensing agency in its deliberations leading to licensure.

\_\_\_\_\_  
(name of program director - print or type)

INSTITUTION

SEAL

\_\_\_\_\_  
(signature of program director)