OKLAHOMA STATE BOARD OF PODIATRIC MEDICAL EXAMINERS
APPLICATION FOR LICENSURE
PLEASE PRINT OR TYPE ALL QUESTIONS

LAST NAME ______________________ **SOCIAL SECURITY #** ______________________

FIRST NAME ______________________ **DATE OF BIRTH** ______________________

MIDDLE NAME ______________________ **PLACE OF BIRTH** ______________________

SUFFIX (ex. JR, SR, II, III) ______________________ **COUNTRY** ______________________

PLEASE LIST ALL MAIDEN, PREVIOUS NAMES AND/OR ALIASES

______________________ ______________________

MAILING ADDRESS ______________________ **SEX** ☐ **MALE** ☐ **FEMALE**

CITY ______________________

STATE ____________ **ZIP CODE** ____________

COUNTRY ______________________

RACE ☐ **Caucasian** ☐ **Black** ☐ **American Indian** ☐ **Hispanic** ☐ **Other** ____________

CELL # ______________________ **HOME #** ______________________

OFFICE # ______________________ **FAX #** ______________________

EMAIL ______________________

PLEASE LIST ALL THE STATES IN WHICH YOU CURRENTLY OR PREVIOUSLY HELD A LICENSE TO PRACTICE

STATE	LIC #	STATE	LIC #

Have you taken the National Board of Podiatric Medical Examiners Examination? ☐ YES ☐ NO
Status: ☐ PENDING ☐ DIPLOMATE

INFORMATION BELOW IS FOR OFFICE USE ONLY – DO NOT COMPLETE

DATE APPLICATION RECEIVED ______________________ **LICENSE NUMBER**

DATE FEE RECEIVED ______________________ **AMOUNT PAID** ______________________

DATE APPROVED ______________________ **DATE LICENSE ISSUED** ______________________

NAME____

ANSWER THE FOLLOWING QUESTIONS – ALL YES ANSWERS MUST INCLUDE A NOTARIZED STATEMENT OF FULL EXPLANATION

A.	Have you ever been denied provider participation, terminated, sanctioned, or penalized by any third party payor, to include TRICARE, MEDICARE, MEDICAID?	☐ YES	☐ NO
B.	Have you ever voluntarily surrendered or had any adverse action taken against any narcotic permit (state or federal)?	☐ YES	☐ NO
C.	Have you been denied membership or had disciplinary action taken by a state or county podiatric society?	☐ YES	☐ NO
D.	Have you ever been denied, had removed, or suspended hospital or staff privileges?	☐ YES	☐ NO
E.	Have you ever surrendered hospital staff privileges while under investigation or to avoid investigation?	☐ YES	☐ NO
F.	Have you ever entered into an agreement with a federal, state or local jurisdictional body to avoid formal action?	☐ YES	☐ NO
G.	Have you ever been the subject of an investigation, probation, or disciplinary action by a hospital, clinic, practice group, training program, or professional school?	☐ YES	☐ NO
H.	Have you had any adverse judgment, settlement, or award against you arising from a professional liability claim?	☐ YES	☐ NO
I.	Have you ever had professional liability coverage declined, canceled, issued on special terms, or renewal refused?	☐ YES	☐ NO
J.	Have you ever been reported to the National Practitioners Data Bank (NPDB)?	☐ YES	☐ NO
K.	Has your application for examination or licensure ever been rejected in this or any other state?	☐ YES	☐ NO
L.	Have you ever failed an examination for licensure? If so, how many times?	☐ YES	☐ NO
M.	Have you ever surrendered a license or had a license revoked?	☐ YES	☐ NO
N.	Has you ever been the subject of disciplinary action by a licensing agency?	☐ YES	☐ NO
O.	Have you ever been charged with or convicted of a felony or misdemeanor, other than traffic violations?	☐ YES	☐ NO
P.	Have you been charged with or convicted of a crime directly or indirectly related to your practice of Podiatry?	☐ YES	☐ NO
Q.	Have you been arrested, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance, including alcohol?	☐ YES	☐ NO
R.	Are you now or have you ever been addicted to or used in excess, any drug or chemical substance, including alcohol?	☐ YES	☐ NO
S.	Have you obtained an assessment for or been treated for the use of any drug or chemical substance, including alcohol?	☐ YES	☐ NO
T.	Do you currently have or have you had any emotional, mental, or physical disorder which, if untreated, could affect your ability to practice competently?	☐ YES	☐ NO

NAME____

PLEASE COMPLETE ALL EDUCATION BELOW (POST GRADUATE TRAINING IS ON THE NEXT PAGE)

HIGH SCHOOL ____

CITY ____________________ **STATE** ____________________ **COUNTRY** ____________________

MO/YR ENTERED __________/__________ **MO/YR COMPLETED** __________/__________

DEGREE AWARDED ____

COLLEGE ____

CITY ____________________ **STATE** ____________________ **COUNTRY**

MO/YR ENTERED __________/__________ **MO/YR COMPLETED** __________/__________

DEGREE AWARDED ____

COLLEGE ____

CITY ____________________ **STATE** ____________________ **COUNTRY**

MO/YR ENTERED __________/__________ **MO/YR COMPLETED** __________/__________

DEGREE AWARDED ____

COLLEGE ____

CITY ____________________ **STATE** ____________________ **COUNTRY**

MO/YR ENTERED __________/__________ **MO/YR COMPLETED** __________/__________

DEGREE AWARDED ____

COLLEGE ____

CITY ____________________ **STATE** ____________________ **COUNTRY**

MO/YR ENTERED __________/__________ **MO/YR COMPLETED** __________/__________

DEGREE AWARDED ____

NAME____

POST GRADUATE TRAINING
PER LAW/RULE – REQUIRES SATISFACTORY COMPLETION OF 3 YEAR PODIATRIC SURGICAL RESIDENCY FOR LICENSURE

HOSPITAL ____

CITY ____________________ STATE ____________________ COUNTRY ____________________

MO/YR ENTERED __________/__________ MO/YR COMPLETED __________/__________

SPECIALTY ____

HOSPITAL ____

CITY ____________________ STATE ____________________ COUNTRY ____________________

MO/YR ENTERED __________/__________ MO/YR COMPLETED __________/__________

SPECIALTY ____

HOSPITAL ____

CITY ____________________ STATE ____________________ COUNTRY

MO/YR ENTERED __________/__________ MO/YR COMPLETED __________/__________

SPECIALTY ____

HOSPITAL ____

CITY ____________________ STATE ____________________ COUNTRY

MO/YR ENTERED __________/__________ MO/YR COMPLETED __________/__________

SPECIALTY ____

HOSPITAL ____

CITY ____________________ STATE ____________________ COUNTRY

MO/YR ENTERED __________/__________ MO/YR COMPLETED __________/__________

SPECIALTY ____

NAME____

PRACTICE HISTORY AND NON-MEDICAL ACTIVITIES (DO NOT INCLUDE TRAINING) – ACCOUNT FOR ALL TIME WITH NO GAPS MORE THAN 90 DAYS

MO/YR START ____/_____ **MO/YR END** ____/_____ **EMPLOYER/ACTIVITY** ________________________________

CITY ____________________ **STATE** ________ **JOB TITLE** ________________________________

MO/YR START ____/_____ **MO/YR END** ____/_____ **EMPLOYER/ACTIVITY** ________________________________

CITY ____________________ **STATE** ________ **JOB TITLE** ________________________________

MO/YR START ____/_____ **MO/YR END** ____/_____ **EMPLOYER/ACTIVITY** ________________________________

CITY ____________________ **STATE** ________ **JOB TITLE** ________________________________

MO/YR START ____/_____ **MO/YR END** ____/_____ **EMPLOYER/ACTIVITY** ________________________________

CITY ____________________ **STATE** ________ **JOB TITLE** ________________________________

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CITY ____________________ **STATE** ________ **JOB TITLE** ________________________________

MO/YR START ____/_____ **MO/YR END** ____/_____ **EMPLOYER/ACTIVITY** ________________________________

CITY ____________________ **STATE** ________ **JOB TITLE** ________________________________

MO/YR START ____/_____ **MO/YR END** ____/_____ **EMPLOYER/ACTIVITY** ________________________________

CITY ____________________ **STATE** ________ **JOB TITLE** ________________________________

NAME____________________________________

CURRENT PRACTICE

ADDRESS ______________________________ CITY ______________ STATE ________ ZIP ________

PHONE NUMBER ______________________________ FAX NUMBER ______________________________

I ATTEST THAT THE INFORMATION PROVIDED IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE

SIGNATURE ____

PLEASE INCLUDE $200 APPLICATION FEE AND THESE ORIGINAL DOCUMENTS WITH THIS APPLICATION:

- ☐ EVIDENCE OF STATUS
- ☐ APPLICATION INSTRUCTIONS
- ☐ PHOTO/OATH
- ☐ NOTARIZED STATEMENT FOR "YES" ANSWERS

MAIL TO:
OKLAHOMA STATE BOARD OF PODIATRIC MEDICAL EXAMINERS
101 NE 51ST STREET
OKLAHOMA CITY, OK 73105

ADDITIONALLY, THESE DOCUMENTS ARE TO BE COMPLETED AND MUST BE SENT DIRECTLY FROM THE SOURCE

- ☐ FORM 1 (MEDICAL SCHOOL)
- ☐ FORM 2 (POST GRADUATE TRAINING – FOR EACH PROGRAM)
- ☐ FORM 5 (CURRENT TRAINING PROGRAM) – IF APPLICABLE
- ☐ FORM 3/LETTER FROM EACH STATE VERIFYING LICENSURE (PAST OR PRESENT)
- ☐ VERIFICATION OF NATIONAL BOARD OF PODIATRIC EXAMINERS

FINALLY, YOU MUST COMPLETE THE EXTENDED BACKGROUND CHECK – OUR OFFICES WILL RETRIEVE THESE DIRECTLY FROM TRAK-1

ONCE YOUR APPLICATION IS RECEIVED AND PROCESSED, YOU WILL RECEIVE AN EMAIL CONTAINING A LETTER WITH YOUR DEFICIENCIES AS WELL AS A LOGIN FOR YOU TO "TRACK" THE STATUS OF YOUR APPLICATION.

SHOULD YOU HAVE ANY ADDITIONAL QUESTIONS, PLEASE EMAIL LICENSING@OKMEDICALBOARD.ORG