Oklahoma Board of Medical Licensure and Supervision
101 NE 51st Street, Oklahoma City, OK 73105
PO Box 18256, Oklahoma City, OK 73154-0256
Main Number – (405)-962-1400 Ext. 118 Fax – 405-962-1499

Request for Public Information – Please print out and mail or fax

I, the undersigned, hereby request the following information:
Check the appropriate boxes:

Data Format:

	Comma Delimited Text
	Excel Format

Delivery Method:

	E-Mail
	CD-ROM

Choose Profession(s): ($120 total for all professions listed below)

✓	*Code*	*Description*	✓	*Code*	*Description*
	AA	Apprentice Athletic Trainer		PT	Physical Therapist
	AT	Licensed Athletic Trainer		TA	Physical therapists Assistant
	MD	Medical Doctor		LD	Licensed Dietitian
	PA	Physician Assistant		PD	Provisionally Licensed Dietitian
	OT	Occupational Therapists		RC	Respiratory care Practitioner
	OA	Occupational Therapy Assistant		PR	Provisional Respiratory Care Practitioner
	RE	Registered Electrologist		RPOA	Registered Prosthetist/Orthotist Assistant
	LPED	Licensed Pedorthist		ROA	Registered Orthotist Assistant
	LPO	Licensed Prosthetist/Orthotist		RTO	Registered Technician – Orthotic
	LPR	Licensed Prosthetist		RTP	Registered Technician – Prosthetic
	LO	Licensed Orthotist		RTPO	Registered Technician – Prosthetic/ Orthotic
	RPA	Registered Prosthetist Assistant		ANA	Anesthesiologist Assistants
	RA	Radiologist Assistants			

The Following Professions require additional charges of $100 for each report:

	POD	Podiatrist		LP	Licensed Perfusionist

	Check here for separate files per profession requested.

Choose License Status: (check all that apply)

	Active

	Inactive*

(*This will include outdated licensees)

Personal Data/Mailing Info:

✓	*Description*	*Sort BY:*	✓	*Description*	*Sort BY:*
	First Name			**Complete Mailing Address**	
	Middle Name			• Address Line 1	
	Last Name			• Address Line 2	
	Suffix (Jr., III)			• Address Line 3	
	Birth Date			• City	
	Birth City			• State	
	Birth Country			• Zip Code	
	Gender (M, F)			• Province (Non USA)	
	Race			• Country	
				• County	

Internal Use Only (Shipped to)

Contact:	**Payment Amount/Method:**
Company Name:	**Total Hours:**
Email Address:	**File Name:**
Delivery Date and Method:	**Completed by:**

DO **NOT** EMAIL THIS FORM
PRINT AND MAIL OR FAX

Practice Address:

✓	*Description*	*Sort BY:*	✓	*Description*	*Sort BY:*
	Complete Practice Address			• State	
	• Address Line 1			• Zip Code	
	• Address Line 2			• Province (Non USA)	
	• Address Line 3			• Country	
	• City			• Practice County	
				• Practice Phone Number	

License Information:

✓	*Description*	*Sort BY:*	✓	*Description*	*Sort BY:*
	License Number			Endorsed By	
	License Issue Date			Supervisor Types (Non-MD Only)	
	License Expiration Date			Supervisor License Number (Non-MD Only)	
	License Status (Active, Inactive)			Supervisor Name (Non-MD Only)	
	Status Class			Specialty 1 (MD Only) – Primary	
	Board Certification 1 (MD Only)			Specialty 2 (MD Only)	
	Board Certification 2 (MD Only)			Specialty 3 (MD Only)	
	Board Certification 3 (MD Only)			Specialty 4 (MD Only)	
				Specialty 5 (MD Only)	
	"Requesting Disciplinary Action and/or Disciplinary Remarks will result in multiple records per license				
	Disciplinary Action			Discipline Remarks	
	Disciplinary Date				

Education:

(Requesting Education information will result in multiple records per licensee).
(One record for each school entry)

✓	*Description*	✓	*Description*
	High School or Undergraduate School Name		Post Graduate School Name
	High School or Undergraduate School City		Post Graduate School City
	High School or Undergraduate School State		Post Graduate School State
	High School or Undergraduate School Country		Post Graduate School Country
	High School or Undergraduate School From Month		Post Graduate School From Month
	High School or Undergraduate School From Year		Post Graduate School From Year
	High School or Undergraduate School To Month		Post Graduate School To Month
	High School or Undergraduate School To Year		Post Graduate School To Year
	High School or Undergraduate School Degree Received		Post Graduate School Degree
	Medical School Name		Medical School City
	Medical School From Month		Medical School Country
	Medical School To Month		Medical School From Year
	Medical School Degree		Medical School To Year

Additional Information

Internal Use Only

Contact:	**City, State, Zip:**
Company Name:	**Phone:** **Ext.**
Address Line 1:	**Fax:**
Address Line2:	**Email: Address:**

DO **NOT** EMAIL THIS FORM
PRINT AND MAIL OR FAX

Please Type

Ship To:

Name			
Company Name			
Address Line 1			
Address Line 2			
Address Line 3			
City, State, ZIP			
Phone	Ext.#		
Fax	Ext.#		
E-Mail Address			

Method of Payment
(Check on one):

☐ **Check (Enclosed)**

☐ **Bill Pay (Credit Card Payment)**
(www.okmedicalboard.org) tab in the middle of the screen.

Enter Bill Pay Transaction ID ☐

Requestor's Signature:_____ **Date:** _____