



Oklahoma Board of Licensure and Supervision
101 NE 51st Street
Oklahoma City, OK 73105

March 18, 2024

Congratulations on the upcoming completion of your 1st or 2nd year of training! The list of attachments is below. Follow instructions on each attachment to avoid delay in processing.

- **QUESTIONNAIRE (ATTACHMENT 1)**
 - This is **YOUR responsibility** to return to OKTRAINING@OKMEDICALBOARD.ORG **DO NOT** give this to your program coordinator, **YOU** must complete and return to our office via email above.
- **FEES FOR UPGRADE OR RENEWAL VIA ONLINE BILLPAY (ATTACHMENT 2)**
- **FORM 2 (ATTACHMENT 3) *FOR UPGRADE OF YOUR LICENSE ONLY**
 - Must be received via email to oktraining@okmedicalboard.org and sent directly from your program chair or coordinator.
 - In order to be eligible for full licensure we must have verification that you have successfully completed the program. Form 2's received before June 30th will not be accepted.
 - Please see the Laws and Rules below regarding this.
- **EVALUATION (ATTACHMENT 4) *FOR RENEWALS AND UPGRADE OF YOUR LICENSE**
 - Must be received via email to oktraining@okmedicalboard.org and sent directly from your program chair or coordinator upon successful completion of your program. Evaluations received before June 30th will not be accepted.

All documentation **MUST** be emailed to OKTRAINING@OKMEDICALBOARD.ORG. Failure to submit documents to the correct email will delay processing. Calling to check on the status of your renewal or upgrade will also delay processing time.

Sincerely,

Lisa K. Cullen
Director of Licensing

OKLAHOMA ALLOPATHIC MEDICAL AND SURGICAL LICENSURE AND SUPERVISION ACT
Title 59 O.S., Sections 480 – 518

493.1. Applicant's Documentation Attested to Board – Qualifications

C. The applicant shall have satisfactorily completed twelve (12) months of progressive postgraduate medical training approved by the Board or by a private nonprofit accrediting body approved by the Board in an institution in the United States, its territories or possessions, or in programs in Canada, England, Scotland, Ireland, Australia or New Zealand approved by the Board or by a private nonprofit accrediting body approved by the Board.

493.2. Foreign applicants – Requirements

D. The Board may promulgate rules requiring all foreign applicants to satisfactorily complete at least twelve (12) months and up to twenty-four (24) months of Board-approved progressive graduate medical training as determined necessary by the Board for the protection of the public health, safety and welfare.

***OKLAHOMA ADMINISTRATIVE CODE**

TITLE 435. STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

435:10-4-4. Application procedure

The applicant shall provide written verification of successful completion of at least twelve (12) months of progressive post-graduate medical training in a program approved by The American Council on Graduate Medical Education (ACGME), The Royal College of Physicians and Surgeons of Canada, The College of Family Physicians of Canada, The Royal College of Surgeons of Edinburgh, The Royal College of Surgeons of England, The Royal College of Physicians and Surgeons of Glasgow, or The Royal College of Surgeons in Ireland. The Board requires this training to be obtained in the same medical specialty.

435:10-4-5. Additional requirements for foreign applicants

(e) An applicant from a foreign medical school shall provide the Board with proof of successful completion of twenty-four (24) months of progressive post-graduate medical training, obtained in the same medical specialty

RETURN FORM TO:
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION
oktraining@okmedicalboard.org

QUESTIONNAIRE

Please read and follow ALL instructions

FORM INSTRUCTIONS: Complete both pages of this form *only if* you are renewing or upgrading your training license. Attach the appropriate documentation and answer the confidential questions.

PAYMENT INSTRUCTIONS: If you **ARE FULLY LICENSED**, you **MUST** go online and renew your license – **DO NOT pay your renewal fee via these instructions (doing so will delay your renewal).**

ATTESTATION STATEMENT: By completing this document, I agree to pay the appropriate fee on **ONLINE BILL PAY** If you are **UPGRADING** your training license to a full license, your fee will be \$250 & you will choose **MD TRAINING-TO-FULL**

If you are **RENEWING** your training license, your fee will be \$150 & you will choose **MD TRAINING LICENSE RENEWAL**

PLEASE PRINT ALL INFORMATION

FIRST NAME	LAST NAME
_____	_____
EMAIL ADDRESS	

LICENSE NUMBER	CELL PHONE
_____	_____
HOME ADDRESS	CITY/STATE
_____	ZIP CODE
PROGRAM ATTENDING	SPECIALTY
_____	_____

DOCUMENTATION TO ATTACH

PAYMENT COMPLETED

<input type="checkbox"/> \$150 payment made on Billpay for RENEWAL of training license	<input type="checkbox"/> \$250 payment made on Billpay for UPGRADE of training license
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DOCUMENTATION REQUIRED

<input type="checkbox"/> Form 2 (must be received directly from program) **ONLY FOR UPGRADE	<input type="checkbox"/> Evaluation (must be received directly from program)
<input type="checkbox"/> USMLE Step 3 (must be received directly from USMLE)	<input type="checkbox"/> Answer confidential questions (on back of this form)

FOREIGN TRAINED STUDENTS

<input type="checkbox"/> Current visa	<input type="checkbox"/> Social Security Number **if not provided at initial application
<input type="checkbox"/> Background Check **if not done at initial application	

IF YOU ARE FULLY LICENSED – DO NOT COMPLETE THIS FORM. YOU MUST GO ONLINE AND RENEW AT <https://pay.apps.ok.gov/medlic/md/login.php> ENTER YOUR LICENSE NUMBER & PIN – COMPLETE YOUR RENEWAL AND PAY THE RENEWAL FEE.

NAME _____

IF YOU HAVE ANY "YES" ANSWERS YOU MUST PROVIDE A NOTARIZED STATEMENT EXPLAINING YOUR ANSWER.

<i>SINCE RENEWAL OF YOUR TRAINING LICENSE OR INITIAL ISSUE OF YOUR TRAINING LICENSE (whichever is most recent)</i>		
QUESTIONS	YES	NO
Have you failed any part of the USMLE exam (not previously disclosed)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been the subject of investigation or disciplinary action (including probation) by a hospital or training program?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any adverse judgment or settlement against you rising from a professional liability claim?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been reported to the National Practitioner Data Bank (NPDB)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been denied, had removed, or suspended hospital privileges?	<input type="checkbox"/>	<input type="checkbox"/>
Have you surrendered hospital privileges while under investigation or to avoid investigation?	<input type="checkbox"/>	<input type="checkbox"/>
Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?	<input type="checkbox"/>	<input type="checkbox"/>
Has your application for licensure ever been denied?	<input type="checkbox"/>	<input type="checkbox"/>
Have you surrendered a license or had any disciplinary action taken on any license?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been investigated by or requested to appear before a licensing or disciplinary agency (other than the Oklahoma State Board of Medical Licensure and Supervision)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than a traffic violation?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been arrested for, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been addicted to or abused any drug or chemical substance including alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been denied provider participation, terminated, sanctioned or penalized by any third-party payor including TRICARE, MEDICARE, or MEDICAID?	<input type="checkbox"/>	<input type="checkbox"/>
Have you surrendered or had any adverse action taken against any narcotic permit (State or Federal)?	<input type="checkbox"/>	<input type="checkbox"/>

I swear under penalty of perjury, that I am the person completing this Questionnaire and understand that any medical license procured or obtained by fraud or misrepresentation will result in disciplinary action taken against the licensee pursuant to the provisions of 59 O.S. § 508.

Signature _____

Date _____

BILLPAY INSTRUCTIONS

RENEWAL PROCESS ONLY

Go to our website www.okmedicalboard.org once you are there you will need to:

1. Look on the right hand side of the page and you will see a **RED BOX that says ONLINE BILL PAY**
2. Click the box that says **SELECT PAYMENT TYPE**
3. Drop down box – choose **MD TRAINING LICENSE RENEWAL & Continue**

At the next screen you need to:

1. You will enter your name, address, phone number, and email address
2. License Number:
3. Reflect payment amount which is: **\$150**
4. Review the information you have entered, if correct select continue
5. You have the option of how you want to pay, choose one and select continue
6. Check and ensure that the billing information is correct
7. Enter your payment information
8. You should be able to print a receipt for your records

UPGRADING FROM TRAINING TO FULL ONLY

Go to our website www.okmedicalboard.org once you are there you will need to:

1. Look on the right hand side of the page and you will see a **RED BOX that says ONLINE BILL PAY**
2. Click the box that says **SELECT PAYMENT TYPE**
3. Drop down box – choose **MD TRAINING-TO-FULL LICENSE FEE 250.00 & Continue**

At the next screen you need to:

1. You will enter your name, address, phone number, and email address
2. License Number:
3. Reflect payment amount which is: **\$250**
4. Review the information you have entered, if correct select continue
5. You have the option of how you want to pay, choose one and select continue
6. Check and ensure that the billing information is correct
7. Enter your payment information
8. You should be able to print a receipt for your records

FULLY LICENSED & NEED TO RENEW FULL LICENSE ONLY

GO TO THE WEBSITE:

<https://www.okmedicalboard.org/renew>

CLICK ON – MD LICENSE RENEWAL/PROFILE UPDATE

CLICK CONTINUE

ENTER LICENSE NUMBER & MEDICAL BOARD PIN – CLICK LOGIN

FOLLOW THE STEPS AS DIRECTED

****IF YOU HAVE QUESTIONS REGARDING YOUR PIN (FULLY LICENSED ONLY)**

CALL LICENSING AT (405) 962-1470 Monday-Friday 8:00am-4:30pm CT

Oklahoma State Board of Medical Licensure and Supervision
 101 NE 51st Street Oklahoma City, OK 73105 ~ (405) 962-1470

Email form to: OKTRAINING@okmedicalboard.org

This form must be completed and sent directly to the Board by the training institution

Verification of Graduate Medical Education

Applicant's Name _____

Institution: _____ City/State _____

Training Level: (e.g. 1, 2, 3, etc.)	____ Specialty/Subspecialty _____	From: ____ / ____ / ____	To: ____ / ____ / ____
		Successfully Completed?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> IN PROGRESS
<input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Chief Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research			
Accredited By: <input type="checkbox"/> ACGME <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/> RCPC <input type="checkbox"/> None of these			

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		Successfully Completed?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> IN PROGRESS
<input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Chief Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research			
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Training Level: (e.g. 1, 2, 3, etc.)	____ Specialty/Subspecialty _____	From: ____ / ____ / ____	To: ____ / ____ / ____
		Successfully Completed?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> IN PROGRESS
<input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Chief Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research			
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Training Level: (e.g. 1, 2, 3, etc.)	____ Specialty/Subspecialty _____	From: ____ / ____ / ____	To: ____ / ____ / ____
		Successfully Completed?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> IN PROGRESS
<input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Chief Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research			
Accredited By: <input type="checkbox"/> ACGME <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/> RCPC <input type="checkbox"/> None of these			

- | | | |
|---|------------------------------|-----------------------------|
| 1. Did this individual ever take a leave of absence or break from his/her training? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2. Was this individual ever placed on probation? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 3. Was this individual ever disciplined or placed under investigation? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 4. Were there any negative reports for behavioral reasons ever filed by instructors? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

Please attach separate document for "YES" response(s) from above

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature of the program director (M.D./D.O. only)

Name: _____ Signature _____
 Title of Signatory: _____ Signature Date _____
 Phone: _____ Fax: _____ E-Mail: _____

RETURN FORM TO:
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

oktraining@okmedicalboard.org

FORM **MUST BE** RETURNED BY THE PROGRAM DIRECTOR, NOT THE APPLICANT

ANNUAL EVALUATION – TRAINING LICENSES ONLY

DO NOT COMPLETE FOR FULLY LICENSED PHYSICIANS

Name of Resident (please print) _____

License Number _____ Specialty _____

Institution Name _____

Program Director (please print) _____

Program Director Email _____

Instructions: Please rate each resident according to the scale below. **If the score is rated in the 0 (Poor), 1 (Fair) or 2 (Below Average) YOU MUST PROVIDE WRITTEN DOCUMENTATION REGARDING THIS RATING.**

ASSESSMENT	POOR	FAIR	BELOW AVERAGE	AVERAGE	ABOVE AVERAGE	OUTSTANDING
MEDICAL KNOWLEDGE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
APPLICATION OF MEDICAL KNOWLEDGE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COMMUNICATION SKILLS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STABILITY IN WORKING RELATIONSHIP WITH OTHER PROFESSIONALS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
THE INDIVIDUAL'S PERFORMANCE COMMENSURATE WITH PEER GROUP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

REMARKS/COMMENTS _____

COMPLETED BY (please print) _____

SIGNATURE _____

DATE _____