

**OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION  
P.O. BOX 18256  
OKLAHOMA CITY, OK 73154-0256**

**APPLICATION FOR SPECIAL VOLUNTEER MEDICAL LICENSE**

PRINT OR TYPE ANSWERS TO **ALL QUESTIONS** ON THIS FORM. IF NOT APPLICABLE, MUST PUT N/A.

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LAST NAME: \_\_\_\_\_ MAILING ADDRESS: \_\_\_\_\_  
FIRST NAME: \_\_\_\_\_ STREET / P.O. BOX: \_\_\_\_\_  
MIDDLE NAME: \_\_\_\_\_ CITY: \_\_\_\_\_  
SUFFIX: \_\_\_\_\_ SOC. SEC. NUMBER: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

**LICENSURE**

LIST ALL JURISDICTIONS, INCLUDING OKLAHOMA (IF APPLICABLE), IN WHICH YOU ARE LICENSED OR IN WHICH YOU WERE PREVIOUSLY LICENSED:

\_\_\_\_\_  
\_\_\_\_\_

**PHOTOGRAPH**

MOUNT PHOTOGRAPH HERE  
IMPORTANT: AFFIX NOTARY SEAL  
PARTIALLY ON THE PHOTO AND  
PARTIALLY ON THE APPLICATION

THIS PHOTOGRAPH, TAKEN WITHIN THE PAST  
TWELVE MONTHS, IS A CORRECT LIKENESS OF  
MYSELF.

\_\_\_\_\_  
APPLICANT SIGNATURE

\_\_\_\_\_  
NOTARY SIGNATURE

COMMISSION NUMBER: \_\_\_\_\_ MY COMMISSION EXPIRES: \_\_\_\_\_

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**DO NOT WRITE BELOW THIS LINE - FOR OFFICE USE ONLY**

APPLICATION RECEIVED \_\_\_\_\_ DATE APPROVED \_\_\_\_\_

COMMENTS: \_\_\_\_\_



**OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE & SUPERVISION  
P. O. BOX 18256, OKLAHOMA CITY, OK 73154-0256  
(405) 962-1400  
e-mail: [licensing@okmedicalboard.org](mailto:licensing@okmedicalboard.org)**

**Volunteer Practice Setting Information**

(Please print or type)

NAME OF PHYSICIAN: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
\_\_\_\_\_

Volunteer Practice Location: Remote Area Medical mobile clinic — Oklahoma State Fair Park / July 9 – 11  
Name of Facility

Travel & Transportation Building, 333 Gordon Cooper Blvd.  
Address

<u>Oklahoma City</u>	<u>OK</u>	<u>73107</u>	<u>(405) 410-5411</u>
City	State	Zip Code	Telephone Number

**I hereby certify under oath that in accordance with Title 59 O.S., §493.5, the services being provided at the facility listed above are for the sole treatment of indigent and needy persons or persons in a medically underserved area and the services are being provided without the expectation of receiving any payment or compensation. Additionally, I understand that I may not practice at this facility until authorization from the Board is received; and, if I desire to change facilities that I must obtain prior approval from the Board.**

\_\_\_\_\_  
Signature of Physician

Sworn to before me this date: \_\_\_\_\_

\_\_\_\_\_  
Notary Public

(SEAL)

Commission Number: \_\_\_\_\_

My commission expires: \_\_\_\_\_