

Oklahoma State Board of Medical Licensure and Supervision  
P.O. Box 18256, Oklahoma City, OK 73154-0256

VERIFICATION OF CLINICAL CLERKSHIP

In the event a foreign medical school utilized clerkships in the United States, its territories or possessions, and the applicant graduated from medical school after July 1, 2003, such clerkships shall have been performed in hospitals and schools that have programs accredited by the Accreditation Council for Graduate Medical Education (ACGME).

**One form must be completed and mailed directly to the Board for each clerkship.**

This is to certify that \_\_\_\_\_;  
Student's Name U.S. Social Security Number

\_\_\_\_\_ a student of \_\_\_\_\_  
Date of Birth Medical School

Completed a clerkship offered by \_\_\_\_\_  
Name of Facility

\_\_\_\_\_  
Address of Facility

From \_\_\_\_\_ through \_\_\_\_\_ in the clinical area  
Month Day Year Month Day Year

Of \_\_\_\_\_  
Clinical Area

This facility has programs that are accredited by ACGME in the areas of \_\_\_\_\_  
Specialty

I, \_\_\_\_\_, swear or affirm that I am/was the individual facility program director or instructor for the student named above during the clerkship indicated and that I have carefully read and completed this form and that the statements made herein are accurate.

Institution  
Seal

\_\_\_\_\_  
Type or Print Name of Facility Program Director or Instructor

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip Code

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Signature

In the absence of an official institution seal, the Facility Program Director or Instructor's signature must be notarized.

Signed and sworn before me this \_\_\_\_\_ day of \_\_\_\_\_ (Month) \_\_\_\_\_ (Year).

Notary  
Seal

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

My Commission Expires: \_\_\_\_\_