OKLAHOMA
State Department
of Health

Oklahoma State Department of Health
Consumer Health Service
PO Box 268815, Oklahoma City, OK 73126-8815
p. (405) 426-8250 f. (405) 900-7557
CHSLicensing@health.ok.gov

MEDICAL MICROPIGMENTATION APPLICATION FORM

License Application Fee: $500.00 Background Check Fee: $15.00 Total Due: $515.00

Check applicable certification: ☐ Newly Trained or ☐ Reciprocity (licensed & in good-standing in another state)

PERSONAL INFORMATION

Name: _____ _____ _____
Last First Middle

If you ever have been known by any other name, please list those names: _____

_____

If name change was made by court order, enclose herein a Certified Copy of such order.

If married woman, give maiden name: _____

Date of Birth: _____ Social Security #: _____

CONTACT INFORMATION

Mailing Address: _____
Street Address City State Zip

Email Address: _____ Telephone #: _____

List residences where you have lived for the past five years, but no more than two residences:

			From:	To:
Street Address	City	State	Mo.& Yr.	Mo. & Yr.
Street Address	City	State	Mo. & Yr.	Mo. & Yr.

CONDUCT

An OSBI background check is required of all applicants. Please do **NOT** submit a background check with your application. OSDH will submit all necessary information upon receipt of this application.

Have you ever been convicted of or plead guilty or nolo contendere to a felony or a misdemeanor involving moral turpitude in any federal, state, territory or District of Columbia court? ☐ Yes ☐ No

If Yes, please explain: _____

Have you ever had a health related license, certificate or permit suspended, revoked or not renewed or had any other disciplinary action taken, or had an application for a health related license, certificate, or permit refused by a federal, state, territory, or District of Columbia regulatory authority? ☐ Yes ☐ No

If Yes, please explain: _____

(Retain a copy of completed application and documents for your record.)

SUPERVISING PHYSICIAN INFORMATION

Supervising Physician's Name: _____ License # _____

Licensing Board: _____

Office Name of Supervising Physician: _____

Supervising Physician's Address: _____
Street Address City State Zip

Telephone #: _____ Fax #: _____

Physician Signature: _____

Supervising Physician's Name: _____ License # _____

Licensing Board: _____

Office Name of Supervising Physician: _____

Supervising Physician's Address: _____
Street Address City State Zip

Telephone #: _____ Fax #: _____

Physician Signature: _____

Supervising Physician's Name: _____ License # _____

Licensing Board: _____

Office Name of Supervising Physician: _____

Supervising Physician's Address: _____
Street Address City State Zip

Telephone #: _____ Fax #: _____

Physician Signature: _____

APPLICATION CHECKLIST

An individual shall be eligible to apply for a certificate to practice medical micropigmentation by satisfying all of the following criteria. **Please submit the following with the completed application and correct fee:**

- ☐ Affidavit of Lawful Presence
- ☐ Documentation of High-School completion or its equivalent and high school phone #: _____
- ☐ Notarized copy of certificate of birth
- ☐ Notarized copy of driver's license or other similar government issued photo identification
- ☐ Proof of successful completion of an OSDH-approved medical micropigmentation training program (or equivalent training program for reciprocal license applicants)
- ☐ Copy of active, out-of-state certificate/license in good-standing (reciprocal certification applicants only)
- ☐ Notarized copy of credentials and professional résumé that document years of practice and number of procedures (reciprocal certification applicants only)

I HEREBY CERTIFY that the information given on this application and the documentation provided is true and correct.

Signature: _____ **Date:** _____