OSBI MENTAL HEALTH CERTIFICATION FORM

LEAVE BLANK. FOR OSBI USE ONLY.

SDA APPLICANT NAME: _____ SEX: _____ RACE: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

The above listed applicant has applied for a handgun license through the Oklahoma State Bureau of Investigation. A background investigation has revealed a possible preclusion under the following section of the Oklahoma Self-Defense Act:

§1290.10 (7) precludes eligibility for a handgun license in the event that a person is "Currently undergoing treatment for a mental illness, condition, or disorder. For purposes of this paragraph, "currently undergoing treatment for a mental illness, condition, or disorder" means the person has been diagnosed by a licensed physician as being afflicted with a substantial disorder of thought, mood, perception, psychological orientation, or memory that significantly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life."

§1290.11 (A) (4) precludes eligibility for a handgun license in the event that "the person has previously undergone treatment for a mental illness, condition, or disorder which required medication or supervision as defined by paragraph 7 of Section 1290.10 of this title. The preclusive period shall be three (3) years from the last date of treatment or upon presentation of a certified statement from a licensed physician stating that the person is either no longer disabled by any mental or psychiatric illness, condition, or disorder or that the person has been stabilized on medication for ten (10) years or more."

Please have the treating physician certify one of the statements below and return the signed, notarized original with the application or mail to:

OSBI SDA LICENSING UNIT
6600 NORTH HARVEY PLACE
OKLAHOMA CITY, OK 73116

Should you have any questions, please contact the Self-Defense Act Licensing Unit at (405) 879-2690.

☐ I certify that the individual listed above has not been diagnosed with or is no longer disabled by any mental illness, condition, or disorder as defined in 1290.10 (7) above.

☐ I certify that the individual listed above is not currently undergoing treatment and has not had treatment in the last three (3) years, including the taking of medication for, any mental illness, condition, or disorder as defined in 1290.10 (7) above.

☐ I certify that the individual listed above has been stabilized on medication for a mental illness, condition, or disorder as defined in 1290.10 (7) above for ten (10) years or more.

☐ I am unable to certify any of the above statements.

_____ _____ _____

Physician Name (Please Print) Physician Signature Medical License #

Physician Address _____

Subscribed and sworn to before me this _____ day of _____

_____.

Notary Public

Form must be signed by a licensed physician and notarized.