



**STATE OF MISSOURI**  
 DIVISION OF PROFESSIONAL REGISTRATION  
**APPLICATION FOR PROVISIONAL VETERINARY LICENSURE**

MISSOURI VETERINARY MEDICAL BOARD  
 3605 MISSOURI BOULEVARD  
 P.O. BOX 633  
 JEFFERSON CITY, MO 65102

**INSTRUCTIONS**

1. Complete all sections below.
2. The provisional license applicant must submit an application for permanent licensure along with the required attachments and it must be completed prior to issuance of a provisional license.
3. After the application for provisional license is completed, please return it, along with the \$25 fee, to the following central office address:  
 Missouri Veterinary Medical Board  
 3605 Missouri Boulevard  
 P.O. Box 633  
 Jefferson City, Missouri 65102  
 573/751-0031

A provisional license issued under sections 340.246 and 340.248 may be revoked by a majority vote of the board without a hearing.

**TO BE COMPLETED BY PROVISIONAL LICENSE APPLICANT**

NAME OF APPLICANT (Please **Type** or **Print**)

SOCIAL SECURITY NUMBER	DATE OF BIRTH	TELEPHONE NUMBER WHERE YOU CAN BE REACHED
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RESIDENTIAL ADDRESS (STREET, CITY, STATE, ZIP CODE)

Pursuant to Section 324.010 RSMo:

**CHECK THIS BOX ONLY IF IN ALL OF THE LAST 3 YEARS: YOU WERE NOT A MISSOURI RESIDENT, YOU DID NOT HAVE ANY MISSOURI INCOME, AND YOU ARE NOT SUBJECT TO ANY TYPE OF MISSOURI INCOME TAX.**

*False statements are subject to criminal penalties and/or license discipline.*

If you have any questions regarding taxes contact the Department of Revenue at 573-751-7200 or e-mail [income@dor.mo.gov](mailto:income@dor.mo.gov).

As a condition to the issuance of this provisional license, I acknowledge and consent to the board's exclusive authority to revoke the same with or without formal hearing as to cause.

DATE	PROVISIONAL LICENSE APPLICANT ▶ _____, DVM
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**TO BE COMPLETED BY SUPERVISING VETERINARIAN**

NAME OF PRIMARY SUPERVISING VETERINARIAN (Please <b>Type</b> or <b>PRINT</b> )	LICENSE NUMBER
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NAME OF SECONDARY SUPERVISING VETERINARIAN (Please <b>Type</b> or <b>Print</b> ), IF APPLICABLE	LICENSE NUMBER
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FACILITY NAME	FACILITY PERMIT NO.
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ADDRESS (STREET, CITY, STATE, ZIP CODE)

I certify that the above named applicant will be practicing veterinary medicine in the state of Missouri under my supervision until s/he can obtain a permanent license. Such supervision shall be consistent with the designated animal health care task.

I accept responsibility for the above named applicant and agree to notify the board and return the provisional license within ten (10) days of termination of his/her employment.

DATE	PRIMARY SUPERVISING VETERINARIAN ▶ _____, DVM
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DATE	SECONDARY SUPERVISING VETERINARIAN, IF APPLICABLE ▶ _____, DVM
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NOTARY PUBLIC EMBOSSE OR BLACK RUBBER STAMP SEAL	STATE	COUNTY (OR CITY OF ST. LOUIS)
	SUBSCRIBED AND SWORN BEFORE ME, THIS DAY OF _____ YEAR _____	
	<b>USE RUBBER STAMP IN CLEAR AREA BELOW.</b>	
	NOTARY PUBLIC SIGNATURE	MY COMMISSION EXPIRES
NOTARY PUBLIC NAME (TYPED OR PRINTED)		