



State Medical Board of Ohio

30 E. Broad St., 3rd Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: <http://med.ohio.gov/>

RE: Certificate of Conceded Eminence

Dear Doctor:

Attached is an application and instructions for a Certificate of Conceded Eminence. **PLEASE READ THE INSTRUCTIONS THOROUGHLY BEFORE COMPLETING THE APPLICATION.** You must complete the entire application and submit all required documentation.

Please note that once submitted an application cannot be withdrawn without the approval of the Board. Fees submitted are neither refundable nor transferable, even if a withdrawal is permitted.

Ohio law does not provide for temporary or provisional licensure while your application for a Certificate of Conceded Eminence is being processed. Practice prior to issuance of a Certificate of Conceded Eminence constitutes the illegal practice of medicine.

The application processing time for a Certificate of Conceded Eminence is ordinarily 4 to 6 weeks after receipt of an application by the Board. An incomplete application or any unusual circumstances may require additional processing time.

ELIGIBILITY FOR A CERTIFICATE OF CONCEDED EMINENCE

To be eligible for a Certificate of Conceded Eminence pursuant to Section 4731.297, Ohio Revised Code, you must:

- Be an international medical graduate who holds a medical degree from an educational institution listed in the international medical education directory.
- Be appointed to serve in this state as a full-time faculty member of a medical school accredited by the Liaison Committee on Medical Education or an osteopathic medical school accredited by the American Osteopathic Association.
- Have accepted an offer of employment with an academic medical center in Ohio or affiliated physician group practice in Ohio.
- Hold a license in good standing in another state or country authorizing the practice of medicine and surgery or osteopathic medicine and surgery.
- Have received staff membership or professional privileges from the academic medical center pursuant to standards adopted on a basis that requires the medical education and graduate medical education to be at least equivalent to that of a physician educated and trained in the United States.
- Have sufficient written and oral English skills to communicate effectively and reliably with patients, their families and other medical professionals.
- Have professional liability insurance through your employment with the academic medical center or affiliated physician group practice.
- Have unique talents and extraordinary abilities not generally found within your specialty as demonstrated by at least 4 of the following:
 - o Educational qualifications beyond those required for entry into your specialty, including advanced degrees, special certifications or other academic credentials.
 - o Written multiple articles in journals listed in the index medicus or an equivalent scholarly publication acceptable to the Board.
 - o Sustained record of excellence in original research, at least some of which involves serving as the principal investigator or co-principal investigator for a research project.
 - o Received nationally or internationally recognized prizes or awards for excellence.
 - o Participated in peer review in a field of specialization that is the same or similar to your specialty.

- Developed new procedures or treatments for complex medical problems that are recognized by peers as a significant advancement in the applicable field of medicine.
 - Held previous academic appointments with or been employed by a health care organization that has a distinguished national or international reputation.
 - Recipient of a National Institutes of Health or other competitive grant award.
- Provide three (3) letters of reference from distinguished experts in your specialty attesting to your unique capabilities, at least one of which must be from outside the academic medical center or affiliated physician group practice.
 - Provide an affidavit from the dean of the medical school where you have been appointed to serve as a faculty member stating that you meet all of the requirements of section 4731.297 of the Ohio Revised Code and that the letters of reference submitted are from distinguished experts in your specialty, and documentation to support the affidavit;
 - Provide a curriculum vitae outlining your qualifications and experience.

The holder of a Certificate of Conceded Eminence may practice medicine and surgery or osteopathic medicine and surgery only within the clinical setting of the academic medical center with which you are employed or for the affiliated physician group practice with which you are employed. You may supervise medical students, physicians participating in graduate medical education, advanced practice nurses and physician assistants when performing clinical services in your area of specialty. The Board may revoke a certificate on receiving proof satisfactory to the Board that the certificate holder has engaged in practice in this state outside the scope of the certificate or that there are grounds for action against the certificate holder under section 4731.22 of the Revised Code.

A Certificate of Conceded Eminence is valid for the shorter of two (2) years or the duration of your employment with the academic medical center or affiliated physician group practice, except that the certificate ceases to be valid if you resign or are otherwise terminated from the academic medical center or affiliated physician group practice.

A Certificate of Conceded Eminence may be renewed for an additional two-year period. There is no limit on the number of times a certificate may be renewed. A person seeking renewal of a certificate shall apply to the Board.

**CERTIFICATE OF CONCEDED EMINENCE
MEDICINE OR OSTEOPATHIC MEDICINE**

APPLICATION INSTRUCTIONS

Review the following instructions and the entire application packet carefully before completing the application. Processing will not begin until the appropriate fee is received. Failure to submit all required information and documentation will result in processing delays. This application form should be used for an original application and any renewal filing.

1. Complete the enclosed **APPLICATION FOR A CERTIFICATE OF CONCEDED EMINENCE - MEDICINE OR OSTEOPATHIC MEDICINE** in its entirety. You must provide a response to each section or question of the application as instructed. Mark "N/A" if Not Applicable.
2. Attach a recent (taken within the last six months) passport-type size **COLOR** photograph of yourself to the Physical Description section in the application. Black and white photographs will not be accepted.
3. Submit a check or money order in the amount of **\$1,000.00** made payable to **Treasurer, State of Ohio** with your application. **FEES ARE NEITHER REFUNDABLE NOR TRANSFERABLE.**
4. Enclose a photocopy of your medical school diploma. If your diploma is not in English or is in Latin, you must also enclose an official certified translation. The translator must attest to the translation and sign and date the translation in the presence of a notary or officer authorized to administer oaths. The translation must be made by one of the following individuals or institutions:
 - a) A professor of languages in the language of your diploma, the translation must bear the letterhead of the institution at which he/she is a professor; or
 - b) Your medical school of graduation. The translation must bear the letterhead of the institution (certificates of graduation are not acceptable); or
 - c) A recognized translation service in the United States (e.g., Berlitz). The translation service must be in the business of performing such translations and properly registered in the state of operation, if so required; or
 - d) A foreign embassy or consulate authorized to perform translations. The translation must be performed by an employee of the embassy or consulate. Translations performed by a non-employee or an embassy or consulate where the translator's signature is merely certified by the embassy are NOT acceptable; or
 - e) A priest or cleric only in the case of Latin documents.

Translations by friends, relatives or yourself are not acceptable.

5. If you have changed your name you must submit a photocopy of the appropriate legal document which authorizes the name change (i.e., marriage certificate, divorce decree). Any document not in English must be accompanied by an official, certified translation in English as provided in instruction #4 above.
6. Enclose a copy of a current, unrestricted license or other document certifying the right to practice medicine or osteopathic medicine or surgery issued by another state or country (i.e., certificate, wallet card) showing expiration date. Any document not in English must be accompanied by an official, certified translation in English as provided in instruction #4 above.
7. See the enclosed Form 1 - Verification of Eligibility Instructions. As part of the Form 1 the Dean of the Medical School where the applicant has been appointed to serve as a faculty member will need to complete the affidavit of verification, submit a Dean's letter, and provide a copy of the employment contract between the facility and applicant.

Additional Information Section

Please keep a copy of the Additional Information questions for your own reference. If any answers to these questions change while your application is pending, you must notify the State Medical Board of Ohio in writing.



State Medical Board of Ohio

30 E. Broad St., 3rd Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: <http://med.ohio.gov/>

APPLICATION FOR CERTIFICATE OF CONCEDED EMINENCE MEDICINE OR OSTEOPATHIC MEDICINE

NOTE: Application fee is \$1,000.00. Fees submitted are neither refundable nor transferable.

PLEASE TYPE OR PRINT CLEARLY

Identification

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. §1320a-7e(b), 5 U.S.C. §552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. §666 and §3123.50, O.R.C.). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. §11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with Chapters 4730., 4731., 4760. or 4762., O.R.C. or as otherwise required by state or federal law.

U.S. Social
Security Number:
(if applicable)

--

Full Name
(Use no
initials):

Last (Surname)	First	Middle	Suffix (Jr., II)
----------------	-------	--------	------------------

Maiden Name
or Other
Names
Used (If none,
enter "NONE"):

Last (Surname)	First	Middle	Suffix (Jr., II)
----------------	-------	--------	------------------

Current
Address:

Number & Street			
City	State	Zip Code	Country

Telephone
Number:

Business:

Area Code & Number ()

Home:

Area Code & Number ()

Birth
Date:

Mo/Day/Yr / /

Birth
Place:

City	State	Country
------	-------	---------

Email Address:

--

Immigration or citizenship status: Indicate which of the following document(s) you currently possess:

- | | |
|---|---|
| <input type="checkbox"/> U.S. Birth Certificate | <input type="checkbox"/> Alien Registration Receipt card (issued by the Department of Immigration & Naturalization) |
| <input type="checkbox"/> Certificate of Naturalization | <input type="checkbox"/> Approved Petition for an Immigrant Visa (issued by the Department of Immigration) |
| <input type="checkbox"/> Declaration of Intention (issued by the U.S. District Court) | <input type="checkbox"/> Other (please specify): _____ |

Medical or Osteopathic Education

Medical or
Osteopathic
School of
Graduation:

School Name		
City	State	Country

Dates Attended: From: Mo/Yr
/ To: Mo/Yr
/

Degree Received: Date Received Mo/Day/Yr
/ /

Unique Talents and Extraordinary Abilities

Check all that apply. You must satisfy at least 4 and provide supporting documentation.

- Achieved educational qualifications beyond those required for entry into my specialty
- Written multiple articles in journals listed in the index medicus or an equivalent scholarly publication
- Sustained record of excellence in original research, at least some of which involves serving as the principal investigator or co-principal investigator for a research project
- Nationally or internationally recognized prizes or awards for excellence
- Participated in peer review in a field of specialization that is the same or similar to my specialty
- Developed new procedures or treatments for complex medical problems that are recognized by peers as a significant advancement in the applicable field of medicine
- Held previous academic appointments with or been employed by a health care organization that has a distinguished national or international reputation
- Recipient of a National Institutes of Health or other competitive grant award

Applicant Name: _____

Date: _____

State Medical Board of Ohio
Certificate of Conceded Eminence - Resume of Activities
Page 2

From Month/Year <hr style="width: 50%; margin: 0 auto;"/> / <hr style="width: 50%; margin: 0 auto;"/> To Month/Year <hr style="width: 50%; margin: 0 auto;"/> / <hr style="width: 50%; margin: 0 auto;"/>	Hospital, University, Other or non-working activity <hr/> Complete Street Address <hr/> Number & Street <hr/> City State/Country Zip Code	Position & Department	%Clinical <hr style="width: 50%; margin: 0 auto;"/> %Admin.
From Month/Year <hr style="width: 50%; margin: 0 auto;"/> / <hr style="width: 50%; margin: 0 auto;"/> To Month/Year <hr style="width: 50%; margin: 0 auto;"/> / <hr style="width: 50%; margin: 0 auto;"/>	Hospital, University, Other or non-working activity <hr/> Complete Street Address <hr/> Number & Street <hr/> City State/Country Zip Code	Position & Department	%Clinical <hr style="width: 50%; margin: 0 auto;"/> %Admin.
From Month/Year <hr style="width: 50%; margin: 0 auto;"/> / <hr style="width: 50%; margin: 0 auto;"/> To Month/Year <hr style="width: 50%; margin: 0 auto;"/> / <hr style="width: 50%; margin: 0 auto;"/>	Hospital, University, Other or non-working activity <hr/> Complete Street Address <hr/> Number & Street <hr/> City State/Country Zip Code	Position & Department	%Clinical <hr style="width: 50%; margin: 0 auto;"/> %Admin.
From Month/Year <hr style="width: 50%; margin: 0 auto;"/> / <hr style="width: 50%; margin: 0 auto;"/> To Month/Year <hr style="width: 50%; margin: 0 auto;"/> / <hr style="width: 50%; margin: 0 auto;"/>	Hospital, University, Other or non-working activity <hr/> Complete Street Address <hr/> Number & Street <hr/> City State/Country Zip Code	Position & Department	%Clinical <hr style="width: 50%; margin: 0 auto;"/> %Admin.
From Month/Year <hr style="width: 50%; margin: 0 auto;"/> / <hr style="width: 50%; margin: 0 auto;"/> To Month/Year <hr style="width: 50%; margin: 0 auto;"/> / <hr style="width: 50%; margin: 0 auto;"/>	Hospital, University, Other or non-working activity <hr/> Complete Street Address <hr/> Number & Street <hr/> City State/Country Zip Code	Position & Department	%Clinical <hr style="width: 50%; margin: 0 auto;"/> %Admin.
From Month/Year <hr style="width: 50%; margin: 0 auto;"/> / <hr style="width: 50%; margin: 0 auto;"/> To Month/Year <hr style="width: 50%; margin: 0 auto;"/> / <hr style="width: 50%; margin: 0 auto;"/>	Hospital, University, Other or non-working activity <hr/> Complete Street Address <hr/> Number & Street <hr/> City State/Country Zip Code	Position & Department	%Clinical <hr style="width: 50%; margin: 0 auto;"/> %Admin.

Applicant Name: _____ Date: _____

**CERTIFICATE OF CONCEDED EMINENCE
 MEDICINE OR OSTEOPATHIC MEDICINE
 ADDITIONAL INFORMATION**

If you answer "YES" to any of the following questions, you are required to furnish complete details, including date, place, reason and disposition of the matter. All affirmative answers must be thoroughly explained on a separate sheet of paper. Please note that some questions require very specific and detailed information. Make sure all responses are complete. For renewal applicants, provide responses since the time of last filing an application for a certificate of conceded eminence.

(Please place a in the yes or no box)

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Have you ever been denied staff membership at any hospital, nursing home, clinic, health maintenance organization, or similar institution? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, had privileges suspended or terminated, been put on probation, or been requested to withdraw from or resign privileges at any hospital, nursing home, clinic, health maintenance organization, or other similar institution in which you have trained, been a staff member, or held privileges, for reasons other than failure to maintain records on a timely basis, or failure to attend staff or section meetings? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever resigned from, withdrawn from, or terminated, or have you ever been requested to resign from, withdraw from, or otherwise been terminated from, a position with a medical partnership, professional association, corporation, health maintenance organization, or other medical practice organization, either private or public? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever resigned from, withdrawn from, or have you ever been warned by, censured by, disciplined by, been put on probation by, been requested to withdraw from, dismissed from, been refused renewal of a contract by, or expelled from, a medical school, clinical clerkship, externship, preceptorship, residency, or graduate medical education program? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever transferred from one graduate medical education program to another? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever, for any reason, lost specialty board certification in the U.S. or elsewhere, or been denied such certification, or denied examination for such certification? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Has any board, bureau, department, agency or other body, including those in Ohio, in any way limited, restricted, suspended, or revoked any professional license, certificate or registration granted to you; placed you on probation; or imposed a fine, censure or reprimand against you? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever voluntarily surrendered, resigned, or otherwise forfeited any professional license, certificate or registration issued to you by any board, bureau, department, agency, or other body; or have you ever withdrawn any application for licensure, relicensure, or examination, in any state (including Ohio), territory, province, or country? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever, for any reason, been denied licensure or relicensure, application for licensure or relicensure, or the privilege of taking an examination, in any state (including Ohio), territory, province, or country? | <input type="checkbox"/> | <input type="checkbox"/> |

Applicant Name: _____

Date: _____

State Medical Board of Ohio
Certificate of Conceded Eminence - Additional Information Questions
Page 2

- | | | YES | NO |
|-----|---|--------------------------|--------------------------|
| 10. | Have you ever been requested to appear before any board, bureau, department, agency, or other body, including those in Ohio, concerning allegations against you? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. | Have you ever entered into an agreement of any kind, whether oral or written, with respect to a professional license, in lieu of or in order to avoid formal disciplinary action, with any board, bureau, department, agency, or other body, including those in Ohio? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. | Have you ever been notified of any investigation concerning you by any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. | Have you ever been notified of any charges, allegations, or complaints filed against you with, any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. | Have you ever been denied, or have you ever surrendered, a state or federal controlled substance or drug registration; had it revoked, terminated, or restricted in any way; or been warned, reprimanded, or fined by, or been requested to appear before, the responsible agency? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. | Have you ever been convicted or found guilty of a violation of any law, or been granted intervention or treatment in lieu of conviction regardless of the legal jurisdiction in which the act was committed, other than a minor traffic violation? If yes, submit copies of all relevant documentation, such as police reports, certified court records and any institutional correspondence and orders. Photocopies will not be accepted. | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. | Have you ever been arrested, forfeited collateral, bail, or bond for breach or violation of any law, police regulation, or ordinance other than for a minor traffic violation; been summoned into court as a defendant or had any lawsuit filed against you (other than a malpractice suit)? If yes, submit copies of all relevant documentation, such as police reports, certified court records and any institutional correspondence and orders. Photocopies will not be accepted. | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. | Have you been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf, or paid such a claim yourself? If yes, you must complete the enclosed malpractice claim information form. In addition, ask your malpractice insurance carrier(s) to provide a complete claims history report for the last 10 years to the State Medical Board of Ohio. If your current carrier has provided coverage for less than 10 years, ask your previous carrier to submit a claims history report to the Board. | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. | Have you ever been denied professional liability insurance or coverage, or had such insurance or coverage canceled, limited, or restricted in any way? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. | Have you ever been denied or relinquished participation in any third party reimbursement program, whether governmental or private, including Medicaid and Medicare; or had such participation limited, restricted, suspended, or revoked; or been warned, reprimanded, requested to appear before, or fined by the responsible body? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. | Have you ever been denied privileges, or had privileges revoked, suspended, restricted, reduced, or terminated by the Department of Defense, the Veteran's Administration, or any of their respective components? | <input type="checkbox"/> | <input type="checkbox"/> |

Applicant Name: _____

Date: _____

- | | YES | NO |
|--|--------------------------|--------------------------|
| 21. Have you ever been diagnosed as having, or have you been treated for, pedophilia, exhibitionism, or voyeurism? If yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. a) Within the last ten years, have you been diagnosed with or have you been treated for, bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Have you, since attaining the age of eighteen or within the last ten years, whichever period is shorter, been admitted to a hospital or other facility for the treatment of bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder? | <input type="checkbox"/> | <input type="checkbox"/> |

If you answered "YES" to any part of this question, please provide details on a separate sheet, including date(s) of diagnosis or treatment, and a description of your present condition. Include the name, current mailing address, and telephone number of each person who treated you, as well as each facility where you received treatment, and the reason for treatment. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.

For purposes of questions 23 and 24 the following phrases or words have the following meaning:

"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental, or psychological conditions or disorders, such as but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

- | | YES | NO |
|---|--------------------------|--------------------------|
| 23. Do you have, or have you been diagnosed as having, a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? If yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> |
| a) Are the limitations or impairment caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program? If yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> |

If you receive such ongoing treatment or participate in such monitoring program the board will make an individualized assessment of the nature, severity, and duration of the risk associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.

- | | | |
|---|--------------------------|--------------------------|
| b) Are the limitation or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? If yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> |
|---|--------------------------|--------------------------|

Applicant Name: _____

Date: _____

“*Chemical substances*” is to be construed to include alcohol, drugs, or medications including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescribers direction, as well as those used illegally.

- | | YES | NO |
|--|--------------------------|--------------------------|
| 24. Do you use chemical substance(s) which in any way impair or limit your ability to practice medicine with reasonable skill and safety? If yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> |
| a) Are the limitations or impairment caused by your use of chemical substances reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program? If yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> |
| <p>If you receive such ongoing treatment or participate in such monitoring program the board will make an individualized assessment of the nature, severity, and duration of the risk associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.</p> | | |
| b) Are the limitation or impairments caused by your use of chemical substances reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? if yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> |

For purposes of question 25 the following phrases or words have the following meaning:

“*Currently*” does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs may have an ongoing impact on one’s functioning as a licensee, or within the past two years.

“*Illegal use of controlled substances*” means the use of controlled substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed healthcare practitioner.

- | | YES | NO |
|--|--------------------------|--------------------------|
| 25. Are you currently engaged in the illegal use of controlled substances? | <input type="checkbox"/> | <input type="checkbox"/> |
| a) If “YES,” are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not using illegal controlled substances. If yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> |

Applicant Name: _____

Date: _____

FORM 1 – VERIFICATION OF ELIGIBILITY INSTRUCTIONS:

1. Complete the **VERIFICATION OF ELIGIBILITY** (Form 1) and have the form signed by the Dean of the Medical School where the applicant has been appointed to serve as a faculty member.
2. Submit a copy of the employment contract between the applicant and the academic medical center or affiliated physician group practice.
3. Provide a letter from the Dean of the Medical School where the applicant has been appointed to serve as a faculty member. The letter should attest that the letters of reference submitted on behalf of the applicant are from distinguished experts in the applicant's specialty and should further state how the applicant meets the following requirements:
 - (1) That the applicant is an international medical graduate who holds a medical degree from an educational institution listed in the international medical education directory;
 - (2) That the applicant has been appointed to serve in this state as a full-time faculty member of a medical school accredited by the liaison committee on medical education or an osteopathic medical school accredited by the American osteopathic association;
 - (3) That the applicant has accepted an offer of employment with an academic medical center in this state or affiliated physician group practice in this state;
 - (4) That the applicant holds a license in good standing in another state or country authorizing the practice of medicine and surgery or osteopathic medicine and surgery;
 - (5) That the applicant has unique talents and extraordinary abilities not generally found within the applicant's specialty, as demonstrated by satisfying **at least four** of the following:
 - (a) The applicant has achieved educational qualifications beyond those that are required for entry into the applicant's specialty, including advanced degrees, special certifications, or other academic credentials. **(For example: Advanced degrees may include PhD in medically related field or related to the provision of medical care. Special Certifications may include specialty board certifications and/or American college designations.)**
 - (b) The applicant has written multiple articles in journals listed in the index medicus or an equivalent scholarly publication acceptable to the board. **(Please list specific articles which demonstrate a progression in research or patient care and appear in publications with an impact factor of at least 2.)**
 - (c) The applicant has a sustained record of excellence in original research, at least some of which involves serving as the principal investigator or co-principal investigator for a research project. **(A sustained record of excellence should be demonstrated through at least 7 years of progressive clinical and/or research in the development of innovative approaches to diagnosis or treatment, applications of technology and/or models of care that influence care at a national or international level. Please list specific supporting documentation.)**
 - (d) The applicant has received nationally or internationally recognized prizes or awards for excellence. **(Awards/Recognitions should be directly related to the applicant's specialty and related to original research in which the applicant served as the principal or co-principal investigator or related to new procedures or treatments.)**

Awards/Recognitions should be from recognized body for contributions and/or innovation in specialty. Awards/Recognitions should not be from current or past employer, Regional or single health system. Please list supporting documentation.)

(e) The applicant has participated in peer review in a field of specialization that is the same as or similar to the applicant's specialty. **(Peer review may include serving as the editor of a journal in the applicant's area of expertise; peer reviewed funding to support innovations that influence clinical practice nationally or internationally; publication of senior author original research, chapters, reviews, and /or textbooks related to applicant's area of clinical expertise that are widely recognized as influencing the field of medicine nationally or internationally; publication of senior author manuscripts that demonstrate the impact of the applicant's innovation on the quality of care, clinical outcomes, and/or access to care. Please list specific supporting documentation.)**

(f) The applicant has developed new procedures or treatments for complex medical problems that are recognized by peers as a significant advancement in the applicable field of medicine. **(New procedures/ treatments should demonstrate development of innovative approaches to diagnosis or treatment, application of technologies and/or models of care that influence care at a national or international level. Examples may include developing treatment protocols or treatment guidelines that influence the standard of care.)**

(g) The applicant has held previous academic appointments with or been employed by a health care organization that has a distinguished national or international reputation. **(National Ranking/ Reputation should be afforded through U.S. News & World Report or similar entity, ranking should have been achieved during time applicant was appointed or employed with organization. Please list supporting documentation.)**

(h) The applicant has been the recipient of a national institutes of health or other competitive grant award. **(Grant awards should demonstrate progression of funding (i.e., Phase I to Phase II) or receipt of subsequent funding for original research/development of new procedures or treatments for complex medical problems.)**

(6) That the applicant has received staff membership or professional privileges from the academic medical center pursuant to standards adopted under section 3701.351 of the Revised Code on a basis that requires the applicant's medical education and graduate medical education to be at least equivalent to that of a physician educated and trained in the United States;

(7) That the applicant has sufficient written and oral English skills to communicate effectively and reliably with patients, their families, and other medical professionals;

(8) That the applicant will have professional liability insurance through the applicant's employment with the academic medical center or affiliated physician group practice.



State Medical Board of Ohio

30 E. Broad St., 3rd Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: <http://med.ohio.gov/>

CERTIFICATE OF CONCEDED EMINENCE MEDICINE OR OSTEOPATHIC MEDICINE FORM 1 – VERIFICATION OF ELIGIBILITY

This form must be completed and signed by the Dean of the Medical School where the applicant has been appointed to serve as a faculty member. Indicate the specific staff appointment and dates of appointment. Include supporting documentation that applicant is qualified to practice medicine and surgery or osteopathic medicine and surgery and will be permitted to practice only as part of the applicant's employment with an academic medical center or an affiliated physician group practice in Ohio. Return directly to the State Medical Board at the above address.

_____ has been appointed as a full-time faculty member at:
(Name of Applicant)

Name of
Medical
School:

Medical
School
Address:

Street Address		
City	State	Zip Code

Name of Academic Medical Center/Affiliated Physician Group Practice (include address)	Signature of Academic Medical Center/Affiliated Physician Group Practice Representative (print name and title legibly beneath)		Date
	Signature		
	Print name and title		
	Signature		
	Print name and title		
	Signature		
	Print name and title		
	Signature		
	Print name and title		

Effective From:

mo/day/yr / /

To:

mo/day/yr / /

(DATES NOT TO EXCEED 2 YEARS)

Applicant is an international medical graduate who holds a medical degree from _____

Applicant holds a license in good standing in _____

Applicant has unique talents and extraordinary abilities not generally found within the applicant's specialty as demonstrated by:

- Achieving educational qualifications beyond those required for entry into applicant's specialty, including advanced degrees, special certifications or other academic credentials
- Writing multiple articles in journals listed in the index medicus or an equivalent scholarly publication
- A sustained record of excellence in original research, at least some of which involves serving as the principal investigator or co-principal investigator for a research project
- Receiving nationally or internationally recognized prizes or awards for excellence
- Participating in peer review in a field of specialization that is the same or similar to applicant's specialty
- Developing new procedures or treatments for complex medical problems that are recognized by peers as a significant advancement in the applicable field of medicine
- Holding previous academic appointments with or being employed by a health care organization that has a distinguished national or international reputation
- Receiving a National Institutes of Health or other competitive grant award

Applicant has received staff membership or professional privileges from the academic medical center on a basis that requires the applicant's medical education and graduate medical education to be at least equivalent to that of a physician educated and trained in the United States

Applicant has sufficient written and oral English skills to communicate effectively and reliably with patients, their families and other medical professionals

Applicant has professional liability insurance through applicant's employment with the academic medical center or affiliated physician group practice.

The three (3) letters of reference submitted by applicant are from distinguished experts in applicant's specialty.

I hereby certify that the information contained herein is true, accurate and complete to the best of my knowledge, information and belief. I further certify that the applicant is qualified to practice medicine and surgery or Osteopathic medicine and surgery and will be permitted to work only within the clinical setting of the academic medical center or for the affiliated physician group practice.

Signature of Dean

Title

Name (please print clearly)

Date

Telephone Number (include area code)

Subscribed and sworn to before me this _____ day of _____, 20____.

Notary Public

NOTARY SEAL

Date Commission Expires

**CERTIFICATE OF CONCEDED EMINENCE
MEDICINE OR OSTEOPATHIC MEDICINE
AFFIDAVIT AND RELEASE OF APPLICANT**

The affidavit and release below **MUST** be completed by **ALL** applicants. The form must be notarized. Failure of any applicant to submit the affidavit completed and notarized with the application will result in your application being considered as incomplete.

ss STATE OF: _____
 COUNTY OF: _____

I, _____, hereby certify under oath that I am the person named in this application for a Certificate of Conceded Eminence in the State of Ohio; that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished to this Board with respect to my application; and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every respect.

I acknowledge that I have read the general information and instructions for all applicants and that I have answered all questions in compliance with these instructions and understand that the fee I submitted is neither refundable nor transferable.

I agree to practice only within the clinical setting of the academic medical center or for the affiliated physician group practice to which I have been appointed.

I further state that by filing this application for a Certificate of Conceded Eminence in the State of Ohio, I hereby authorize and consent to have an investigation made of me. I agree to give any further information which may be required in reference to my past record. I understand that I will not receive a copy of any reports or know their contents and I further understand that the contents of any investigative report will be privileged.

I further understand that my application for a Certificate of Conceded Eminence in the State of Ohio is an ongoing process. I will immediately notify the State Medical Board of Ohio in writing of any changes to the answers to any of the questions contained in the ADDITIONAL INFORMATION section of the application if such a change in an answer is warranted at any time prior to a Certificate of Conceded Eminence being granted to me by the State Medical Board of Ohio. I further understand that failure to complete this application as requested by the Board within six months can be considered abandonment of any request for a Certificate of Conceded Eminence and that any fee I submitted is neither refundable nor transferable.

I authorize and request every person, hospital, clinic, governmental agency (local, state, federal or foreign), court, association, institution, or law enforcement agency having control of any documents, records and other information pertaining to me to furnish to the State Medical Board of Ohio any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the State Medical Board of Ohio or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application, subsequent to the issuance of a Certificate of Conceded Eminence.

I hereby release, discharge, and exonerate the State Medical Board of Ohio, its agents or representatives and any person, hospital, clinic, governmental agency (local, state, federal or foreign), court, association, institution, or law enforcement agency furnishing information, of any and all liability of every nature and kind arising out of investigation made by the State Medical Board of Ohio. I authorize the State Medical Board of Ohio to release information, material, documents, orders or the like relating to me or to this application to any other governmental agency (local, state, federal or foreign); or to any hospital, nursing home, clinic, health maintenance organization or similar institution; or to any professional association.

I further understand that issuance of a Certificate of Conceded Eminence in Ohio will be considered on the truth of the statements and documents contained herein or to be furnished, which if false, can subject me to revocation of said certificate.

Signature of Applicant

Subscribed and sworn to before me this _____ day of _____ 20 _____.

Signature of Notary Public

(NOTARY SEAL)

Date Commission Expires

CATEGORY 2

(A MAXIMUM OF 90 CREDITS MAY BE EARNED IN THIS CATEGORY)

Name of Sponsor	Location (City & State)	Description	Date(s)	Credits
Example: Self Instruction		Pediatric Journal	7/1/10 thru 3/30/11	90+