



# State Medical Board of Ohio

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

RE: Visiting Clinical Professional Development Certificate

Dear Doctor:

Attached is an application and instructions for a Visiting Clinical Professional Development Certificate. 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Please note that once submitted, an application cannot be withdrawn without the approval of the Board.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 Visiting Clinical Professional Development Certificate is being processed. **Practice prior to issuance of a Visiting Clinical Professional Development Certificate constitutes the illegal practice of medicine.**

The application processing time for a Visiting Clinical Professional Development Certificate is ordinarily 10 to 12 weeks after receipt of an application by the Board. An incomplete application or any unusual circumstances may require additional processing time.

## **ELIGIBILITY FOR A VISITING CLINICAL PROFESSIONAL DEVELOPMENT CERTIFICATE**

To be eligible for a Visiting Clinical Professional Development Certificate pursuant to Section 4731.297, Ohio Revised Code, you must:

- Hold a current, unrestricted license to practice medicine and surgery or osteopathic medicine and surgery issued by another state or country.
- Be accepted for participation in a clinical professional development program of a medical school or osteopathic medical school in Ohio that is accredited by the Liaison Committee on Medical Education or the American Osteopathic Association or of a teaching hospital affiliated with such a medical school.
- Be an international medical graduate, who holds a medical degree from an educational institution listed in the international medical education directory.
- Have practiced medicine and surgery or osteopathic medicine and surgery for at least five years after completing graduate medical education, including postgraduate residency and advanced training.
- Have credentials that are primary-source verified by the educational commission for foreign medical graduates (ECFMG) or the federation credentials verification service (FCVS).
- Agree to comply with all state and federal laws regarding health, healthcare and patient privacy.
- Agree to return to your home state or country at the conclusion of the clinical professional development program.
- Have sufficient financial resources to support yourself and any dependents based on the cost of living in the geographic area of the school or hospital conducting the program, including room, board, transportation and related living expenses.
- Have valid health and evacuation insurance for the duration of your stay in the United States.
- Have professional liability insurance provided by the program or the school or hospital conducting the program for the duration of your participation in the program.
- Be proficient in spoken English as demonstrated by passing the Test of English as a Foreign Language, Internet-based Test (TOEFL IBT).

The holder of a Visiting Clinical Professional Development Certificate may practice medicine and surgery or osteopathic medicine and surgery only as part of the clinical professional development program in which the certificate holder participates. The certificate holder's practice must be under the direct supervision of a qualified faculty member of the medical school, osteopathic medical school or teaching hospital conducting the program who holds a current, unrestricted certificate to practice medicine and surgery or osteopathic medicine and surgery in the State of Ohio. 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 Visiting Clinical Professional Development Certificate is valid for the shorter of one year or the duration of the program in which the holder is participating, except that the certificate ceases to be valid if the holder resigns or is otherwise terminated from the program. The certificate may not be renewed.

The program in which a certificate holder participates shall obtain from each patient or patient's parent or legal guardian, written consent to any medical or surgical procedure or course of procedures in which the certificate holder participates.

**VISITING CLINICAL PROFESSIONAL DEVELOPMENT CERTIFICATE  
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.

1. Complete the FCVS or ECFMG Certification Verification Service (CVS) on-line application.
  - a) The FCVS on-line application is available at [www.fsmb.org](http://www.fsmb.org)
  - b) The ECFMG CVS on-line application is available at [www.ecfm.org](http://www.ecfm.org)
2. Complete the enclosed **APPLICATION FOR A VISITING CLINICAL PROFESSIONAL DEVELOPMENT CERTIFICATE - 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.
3. 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.
4. Submit a check or money order in the amount of **\$375.00** made payable to **Treasurer, State of Ohio** with your application. **FEES ARE NEITHER REFUNDABLE NOR TRANSFERABLE.**
5. 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.

6. 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 #5 above.
7. 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 #5 above.
8. Forward the enclosed Verification of Activity (Form 1) form to the school or hospital conducting the program. In addition, you must submit a copy of your contract.
9. Submit a copy of a valid health and evacuation insurance policy effective for the duration of your stay in the United States.

10. Submit a copy of a valid professional liability insurance policy provided by the program or the school or hospital conducting the program effective for the duration of your participation in the program.

**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

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## APPLICATION FOR VISITING CLINICAL PROFESSIONAL DEVELOPMENT CERTIFICATE MEDICINE OR OSTEOPATHIC MEDICINE

**NOTE: Application fee is \$375.00. 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)

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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
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Email Address:

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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): _____  |

**TOEFL IBT**

(Test of English as a Foreign Language, Internet-based Test)

You must request the Educational Testing Service to forward an official score report to this Board indicating that you have received a score of at least 26 in Speaking and 26 in Listening with a total score of 90 on the TOEFL IBT. If you have not yet taken the TOEFL IBT, you must contact the Educational Testing Service directly to apply. The address and website are:

Educational Testing Service  
P.O. Box 6151  
Princeton, NJ 08541-6151  
(877) 863-3546  
[www.ets.org/](http://www.ets.org/)

**The TOEFL, TWE and ECFMG's English exam (prior to 7/1/98) are not equivalent to and cannot be substituted for the TOEFL IBT.**

**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  
/ /

Applicant Name: \_\_\_\_\_

Date: \_\_\_\_\_



**VISITING CLINICAL PROFESSIONAL DEVELOPMENT CERTIFICATE  
 MEDICINE OR OSTEOPATHIC MEDICINE  
 RESUME OF ACTIVITIES**

List ALL activities in chronological order from the completion of graduate medical education to the PRESENT time, using **MONTH** and **YEAR**. For any *non-working time*, you **MUST** state on the resume exactly what your activities were, such as “vacation” or “seeking employment”, as well as your permanent address. If in private practice, indicate the hospitals where you hold or have held privileges and include complete dates and addresses. For any time in which you worked for an “emergency medical group” or did “locum tenens”, you must list all hospitals where you worked and include complete dates and addresses. **DO NOT SUBSTITUTE ANY OTHER RESUME OR CV FOR THIS FORM.** Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space, please attach separate sheets.

From Month/Year <hr style="width: 50%; margin: 0 auto;"/> / <hr style="width: 50%; margin: 0 auto;"/>	Hospital, University, Other or non-working activity <hr style="border: none; border-top: 1px solid black; margin-top: 5px;"/> Complete Street Address <hr style="border: none; border-top: 1px solid black; margin-top: 5px;"/> Number & Street <hr style="border: none; border-top: 1px solid black; margin-top: 5px;"/> City                      State/Country                      Zip Code	Position & Department	%Clinical <hr style="width: 50%; margin: 0 auto;"/> %Admin.
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 style="border: none; border-top: 1px solid black; margin-top: 5px;"/> Complete Street Address <hr style="border: none; border-top: 1px solid black; margin-top: 5px;"/> Number & Street <hr style="border: none; border-top: 1px solid black; margin-top: 5px;"/> City                      State/Country                      Zip Code	Position & Department	%Clinical <hr style="width: 50%; margin: 0 auto;"/> %Admin.
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Applicant Name: \_\_\_\_\_

Date: \_\_\_\_\_

**State Medical Board of Ohio**  
**Visiting Clinical Professional Development Certificate - 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;"/> /	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;"/> /	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;"/> /	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.
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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;"/> /	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: \_\_\_\_\_

**VISITING CLINICAL PROFESSIONAL DEVELOPMENT CERTIFICATE  
 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.

(Please place a  in the yes or no box)

- |  | <b>YES</b>               | <b>NO</b>                |
|--|--------------------------|--------------------------|
| 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  
**Visiting Clinical Professional Development Certificate - 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, <b>certified</b> 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, <b>certified</b> 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.

- |   | <b>YES</b>               | <b>NO</b>                |
|---|--------------------------|--------------------------|
| 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"/> |
| 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 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.

- |  | <b>YES</b>               | <b>NO</b>                |
|--|--------------------------|--------------------------|
| 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: \_\_\_\_\_

**VISITING CLINICAL PROFESSIONAL DEVELOPMENT CERTIFICATE  
MEDICINE OR OSTEOPATHIC MEDICINE  
MALPRACTICE CLAIM INFORMATION**

This form must be completed if you have been named as a defendant in a malpractice lawsuit, verdict or settlement. *Make additional copies of this form as necessary for multiple claims.*

Name of Physician (print clearly): \_\_\_\_\_

**MALPRACTICE COMPLAINT:**

Name of Patient: \_\_\_\_\_

Patients Gender:     Male     Female    Age of Patient: \_\_\_\_\_

Date of Incident: \_\_\_\_\_    Date Suit Filed: \_\_\_\_\_

Location of incident: \_\_\_\_\_  
Hospital, institution or other

Address \_\_\_\_\_

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

Name and Address of Involved Insurance Carrier: \_\_\_\_\_  
\_\_\_\_\_

**FILED AGAINST:**     Individual Physician     Group     Hospital

Your Position in Case:     Resident     Primary Physician     Other: \_\_\_\_\_

List names of other defendant-physicians and/or hospitals: \_\_\_\_\_  
\_\_\_\_\_

**DISPOSITION:**     Pending     Jury Verdict     Settled     Dismissed     Dropped

If settled, provide the following information:     In Court     Out of Court

Name of Court: \_\_\_\_\_

Date of Settlement: \_\_\_\_\_    Docket #: \_\_\_\_\_

Total amount of settlement: \$ \_\_\_\_\_    Amount attributable to you: \$ \_\_\_\_\_

You must provide a detailed written explanation of the background and medical issues involved in the case. This must be described in your own words. Do not reference attached documentation. If additional space is needed, attach separate sheet. Submit copies of the complaint, answer, release, settlement documents and all other relevant legal documents. Be sure to have your malpractice insurance carrier(s) provide a complete claims history report.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date



# State Medical Board of Ohio

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

## VISITING CLINICAL PROFESSIONAL DEVELOPMENT CERTIFICATE MEDICINE OR OSTEOPATHIC MEDICINE FORM 1 – VERIFICATION OF ACTIVITY

This form must be completed and signed by the Dean of the Medical School or the Department Director or Chairperson of the hospital conducting the program. Indicate the dates of appointment. Include supporting documentation that applicant: (1) has sufficient financial resources to support applicant and any dependents based on the cost of living in the geographic area of the school or hospital conducting the program, including room, board, transportation and related living expenses; (2) has professional liability insurance provided by the program or the school or hospital conducting the program for the duration of the applicant's participation in the program; and (3) is qualified to participate in the visiting clinical professional development program and will be permitted to work only as part of the clinical professional development program and only under the direct supervision of a qualified faculty member of the school or hospital conducting the program who holds a current, unrestricted license to practice medicine and surgery or osteopathic medicine and surgery in the State of Ohio. Return directly to the State Medical Board at the above address.

\_\_\_\_\_ has been accepted for participation in a  
 (Name of Applicant)  
 clinical professional development program at:

Name of  
 Medical  
 School:

Medical  
 School  
 Address

Street Address		
City	State	Zip Code

Affiliated with the following teaching hospitals.

Name of Teaching Hospital (include address)	Signature of Hospital/Medical Director (print name legibly beneath)	Date
	Signature _____	
	Print name legibly _____	
	Signature _____	
	Print name legibly _____	
	Signature _____	
	Print name legibly _____	
	Signature _____	
	Print name legibly _____	

Effective From:

mo/day/yr  
 / /

To:

mo/day/yr  
 / /

**(DATES NOT TO EXCEED 1 YEAR)**

Applicant shall perform the following medical or surgical activities as part of applicant's participation in a clinical professional development program in accordance with Section 4731.297, Ohio Revised Code:

Description  
of Activity: \_\_\_\_\_

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Type of  
Practice: \_\_\_\_\_

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Type of  
Patient Contact: \_\_\_\_\_

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Type of  
Supervision: \_\_\_\_\_

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List of  
Procedures to  
Be Learned: \_\_\_\_\_

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**State Medical Board of Ohio**  
**Visiting Clinical Professional Development Certificate – Medicine or Osteopathic Medicine**  
**Form 1 – Verification of Activity**  
**Page 3**

List of  
Patient-Based  
Research  
Projects: \_\_\_\_\_

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Reason Advanced  
Training Needed: \_\_\_\_\_

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Benefits to Home  
Country: \_\_\_\_\_

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Applicant       will  will not act as a consultant to an Ohio licensed physician.

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 has sufficient financial resources to support the applicant and any dependents based on the cost of living in the geographic area of the school or hospital conducting the program, including room, board, transportation and related living expenses. I further certify that applicant has professional liability insurance provided by the program or the school or hospital conducting the program for the duration of the applicant's participation in the program. I further certify that applicant will not write orders or prescribe medication, bill for services performed, occupy a residency or fellowship position approved by the accreditation council for graduate medical education, or attempt to have participation in the clinical professional development program counted toward meeting graduate medical education requirements. I further certify that applicant meets the eligibility requirements of this certificate and will be permitted to work only as part of the clinical professional development program and only under the direct supervision of a qualified faculty member of the school or teaching hospital conducting the program who holds a current, unrestricted license in the State of Ohio.

\_\_\_\_\_  
Signature of Dean, Department Director or Chairperson

\_\_\_\_\_  
Title

\_\_\_\_\_  
Name (please print clearly)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Telephone Number (include area code)

**Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.**

**NOTARY SEAL**

\_\_\_\_\_  
**Notary Public**

\_\_\_\_\_  
**Date Commission Expires**

**VISITING CLINICAL PROFESSIONAL DEVELOPMENT CERTIFICATE  
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 Visiting Clinical Professional Development Certificate 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 comply with all state and federal laws regarding health, health care and patient privacy. I agree to return to my home state or country at the conclusion of the clinical professional development program.

I further state that by filing this application for a Visiting Clinical Professional Development Certificate 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 Visiting Clinical Professional Development Certificate 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 Visiting Clinical Professional Development Certificate 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 Visiting Clinical Professional Development Certificate 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 Visiting Clinical Professional Development Certificate.

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 Visiting Clinical Professional Development Certificate 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