



# State Medical Board of Ohio

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

RE: Volunteer's Certificate

Dear Doctor:

Attached is an application and instructions for a Volunteer's Certificate. PLEASE READ THE INSTRUCTIONS THOROUGHLY BEFORE COMPLETING THE APPLICATION.

Please note that, once submitted, an application cannot be withdrawn without the approval of the Board.

**Practice prior to issuance of a Volunteer's Certificate constitutes the illegal practice of medicine.**

The application processing time for a Volunteer's Certificate is ordinarily 1 to 3 weeks after receipt of an application by the Board. An incomplete application or any unusual circumstances may require additional processing time.

Enclosures:

## **ELIGIBILITY FOR A VOLUNTEER'S CERTIFICATE**

The Board may issue, without examination, a Volunteer's Certificate to a person who is retired from practice so that the person may provide medical services to indigent and uninsured persons at nonprofit shelters or health care facilities.

To be eligible for a Volunteer's Certificate you must have done one of the following:

- maintained for at least ten years prior to retirement full licensure in good standing in any jurisdiction in the United States that licenses persons to practice medicine and surgery or osteopathic medicine and surgery; or
- practiced for at least ten years prior to retirement in good standing as a doctor of medicine and surgery or osteopathic medicine and surgery in one or more of the branches of the United States Armed Services.

The holder of a Volunteer's Certificate may provide medical services only on the premises of a nonprofit shelter or health care facility and only to indigent and uninsured persons. The holder shall not accept any form of remuneration for providing medical services while in possession of the certificate. Except in a medical emergency, the holder shall not perform any operation or deliver babies. The Board may revoke a Volunteer's Certificate on receiving proof satisfactory to the Board that the holder has engaged in practice in this state outside the scope of the certificate or that there are grounds for action against the person under Section 4731.22, Ohio Revised Code.

## VOLUNTEER'S CERTIFICATE APPLICATION INSTRUCTIONS

(Please read and follow the instructions carefully)

1. Fill out the enclosed **APPLICATION FOR A VOLUNTEER'S CERTIFICATE** in its entirety.
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. 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 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. ANY TRANSLATION SUBMITTED WHICH DOES NOT COMPLY WITH THE ABOVE LISTED INSTRUCTIONS WILL NOT BE ACCEPTED AND WILL RESULT IN DELAY IN PROCESSING YOUR APPLICATION WHILE YOU RESUBMIT AN ACCEPTABLE TRANSLATION.

4. Complete the top portion of the enclosed Verification of License (Form 2) and forward it to a state (excluding Ohio) in which you hold or have held a license to practice medicine or osteopathic medicine.
5. Enclose a copy of your most recent license or certificate authorizing the practice of medicine and surgery or osteopathic medicine and surgery issued by:
  - a) a jurisdiction in the United States that licenses persons to practice medicine and surgery or osteopathic medicine and surgery; or
  - b) one or more branches of the United States Armed Services that the United States government issued.
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 in a foreign language must be accompanied by an official, certified translation as provided in instruction #3 above.
7. Complete the top portion and forward the enclosed Verification of Activity (Form 1) form to the nonprofit shelter or health care facility for completion and its return directly to this Board.

### **Additional Information Section**

Please keep a copy of the Additional Information questions for your own reference. You must notify the State Medical Board of Ohio in writing of any changes to the answers to these questions that may be warranted to ensure that they are both up to date and accurate prior to a training certificate being granted to you by the State Medical Board of Ohio.

### **Licensure and Wall Certificate**

Upon issuance of a Volunteer's Certificate, a letter of notification will be mailed to you. That letter will serve as legal authorization to practice in conjunction with the Volunteer's Certificate. A wallet card and wall certificate will be mailed as soon as possible. The holder of the Volunteer's Certificate shall keep the wallet card on his/her person while providing medical services and shall display the wall certificate prominently in the nonprofit shelter or health care facility where the holder primarily practices.

### **Renewal and Continuing Medical Education:**

A Volunteer's Certificate shall be valid for a period of three years and may be renewed upon the application of the holder. Ohio law also requires 150 hours of continuing medical education for renewal. Information outlining the C.M.E. requirements will be mailed following issuance of the Volunteer's Certificate.



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## APPLICATION FOR VOLUNTEER'S CERTIFICATE

**PLEASE TYPE OR PRINT CLEARLY**

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

-	-
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Full Name  
(Use no initials)

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

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

Last	First	Middle	Suffix (Jr., II)
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Current  
Address

Street Number & Name			
City	State	Zip Code	Country

Telephone Business

Area Code & Number (       )
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Home

Area Code & Number (       )
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### **MEDICAL OR OSTEOPATHIC EDUCATION**

Medical or  
Osteopathic  
School of  
Graduation:

School Name		
City	State	Country

Dated Attended:

From:

MO/YR /
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To:

MO/YR /
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Degree  
Received:

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Date  
Received:

MO/DAY/YR / /
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## VOLUNTEER'S CERTIFICATE RESUME OF ACTIVITIES

List ALL activities in chronological order from the date of graduation 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 FORM 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="border: none; border-top: 1px solid black; margin: 5px 0;"/> /	Hospital, University, Other or non-working activity <hr style="border: none; border-top: 1px solid black; margin: 5px 0;"/>	Position & Department	%Clinical
To Month/Year <hr style="border: none; border-top: 1px solid black; margin: 5px 0;"/> /	Complete Street Address <hr style="border: none; border-top: 1px solid black; margin: 5px 0;"/> Number & Street <hr style="border: none; border-top: 1px solid black; margin: 5px 0;"/> City                                  State/Country                                  Zip Code		<hr style="border: none; border-top: 1px solid black; margin: 5px 0;"/> %Admin.

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From Month/Year <hr style="width: 50%; margin: 0;"/>	Hospital, University, Other or non-working activity <hr style="width: 80%; margin: 0;"/>	Position & Department	%Clinical <hr style="width: 50%; margin: 0;"/>
To Month/Year <hr style="width: 50%; margin: 0;"/>	Complete Street Address <hr style="width: 80%; margin: 0;"/>		
	Number & Street <hr style="width: 80%; margin: 0;"/>		%Admin. <hr style="width: 50%; margin: 0;"/>
	City State/Country Zip Code <hr style="width: 80%; margin: 0;"/>		

From Month/Year <hr style="width: 50%; margin: 0;"/>	Hospital, University, Other or non-working activity <hr style="width: 80%; margin: 0;"/>	Position & Department	%Clinical <hr style="width: 50%; margin: 0;"/>
To Month/Year <hr style="width: 50%; margin: 0;"/>	Complete Street Address <hr style="width: 80%; margin: 0;"/>		
	Number & Street <hr style="width: 80%; margin: 0;"/>		%Admin. <hr style="width: 50%; margin: 0;"/>
	City State/Country Zip Code <hr style="width: 80%; margin: 0;"/>		

From Month/Year <hr style="width: 50%; margin: 0;"/>	Hospital, University, Other or non-working activity <hr style="width: 80%; margin: 0;"/>	Position & Department	%Clinical <hr style="width: 50%; margin: 0;"/>
To Month/Year <hr style="width: 50%; margin: 0;"/>	Complete Street Address <hr style="width: 80%; margin: 0;"/>		
	Number & Street <hr style="width: 80%; margin: 0;"/>		%Admin. <hr style="width: 50%; margin: 0;"/>
	City State/Country Zip Code <hr style="width: 80%; margin: 0;"/>		

From Month/Year <hr style="width: 50%; margin: 0;"/>	Hospital, University, Other or non-working activity <hr style="width: 80%; margin: 0;"/>	Position & Department	%Clinical <hr style="width: 50%; margin: 0;"/>
To Month/Year <hr style="width: 50%; margin: 0;"/>	Complete Street Address <hr style="width: 80%; margin: 0;"/>		
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	City State/Country Zip Code <hr style="width: 80%; margin: 0;"/>		

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	Number & Street <hr style="width: 80%; margin: 0;"/>		%Admin. <hr style="width: 50%; margin: 0;"/>
	City State/Country Zip Code <hr style="width: 80%; margin: 0;"/>		

**VOLUNTEER'S CERTIFICATE  
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.

Place an  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"/> |

- |     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 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, regardless of the legal jurisdiction in which the act was committed, other than a minor traffic violation?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. | Have you ever 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)?                                                                                                                                                                                                                                                                                                                                                                                                                      | <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, include the case name, case number, court and address, date filed, and a summary of the underlying events. Indicate current status, including amount of settlement or judgment, if any. 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"/> |

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

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

- |                                                                                                                                                                                                                                                                                                                                                                                                  | 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.</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:

*“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.

*“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 dangerous substances”* means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous 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 dangerous 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 dangerous substances. If yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> |

**VOLUNTEER'S CERTIFICATE  
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 Volunteer's 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 I have answered all questions in compliance with these instructions. I understand that I will not accept any form of remuneration for any medical services rendered while in possession of a Volunteer's Certificate.

I further state that by filing this application for a Volunteer's Certificate in the State of Ohio, I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness for the Volunteer's Certificate. 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 failure to complete this application as requested by the Board within six months can be considered as abandonment of any request for a registration number and that any fee I submitted is not refundable or 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 registration or practice hereunder.

I hereby release, discharge, and exonerate the State Medical Board of Ohio, its agents or representatives, and any person furnishing information, from 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 consideration of this application is based on the truth of the statements and documents made or furnished in connection with it. If any of the statements are false, I may be permanently denied a Volunteer's Certificate in Ohio.

\_\_\_\_\_  
Signature of Applicant

Sworn to and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Notary Public Signature

**(NOTARY SEAL)**

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



# State Medical Board of Ohio

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

## VOLUNTEER'S CERTIFICATE FORM 1 - VERIFICATION OF ACTIVITY

I am applying for a Volunteer's Certificate in the State of Ohio. Please complete the form and return it directly to the State Medical Board of Ohio at the above address.

### TO BE COMPLETED BY APPLICANT

Full Name (last, first, middle, suffix)

Complete address (number & street)

Date of birth (mo/day/yr)

(city, state & zip)

Medical school of graduation

Signature of applicant

Date

### TO BE COMPLETED BY RESPONSIBLE PHYSICIAN OR OTHER PERSON

This is to certify that the above named applicant will be providing medical services to indigent and uninsured persons in accordance with Section 4731.295, Ohio Revised Code.

Name of nonprofit shelter or health care facility

Location (street, city, state and zip code)

#### SEND CONFIRMATION TO:

Name

Complete street address

City State Zip

Signature

Name (please print clearly or type)

Title

Telephone Number

Date



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## VOLUNTEER'S CERTIFICATE FORM 2 - VERIFICATION OF LICENSE

I am applying for a Volunteer's Certificate to practice medicine or osteopathic medicine in the State of Ohio. The State Medical Board of Ohio requires that this form be completed by a state in which I hold or have held a license, whether now current or not. Please complete the form and return it directly to the State Medical Board of Ohio.

### TO BE COMPLETED BY APPLICANT

Name \_\_\_\_\_  
last first middle suffix (Jr., II)

Current Address \_\_\_\_\_  
Number & Street  
City State Zip Code  
License Number \_\_\_\_\_  
Date of Birth 

mo/day/yr
/ /

Medical/Osteopathic School of Graduation \_\_\_\_\_

I hereby authorize the licensing agency of the State of \_\_\_\_\_ to furnish the information below to the State Medical Board of Ohio.

\_\_\_\_\_  
Signature of Applicant Date

### TO BE COMPLETED BY STATE BOARD OR CANADIAN PROVINCE

State: \_\_\_\_\_

Name of Licensee: \_\_\_\_\_  
last first middle suffix (Jr., II)

License Number \_\_\_\_\_ Issue Date 

mo/day/yr
/ /

 License current?  Yes  No  
If not, please explain \_\_\_\_\_

Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state?  Yes  No  Cannot answer under current state law *If yes, please attach complete details.*

Have formal disciplinary proceedings been initiated against applicant's license by a disciplinary authority in your state?  Yes  No  Cannot answer under current state law *If yes, please attach complete details.*

Has the applicant ever been warned, censured or in any other manner disciplined or has applicant's license been revoked, suspended, or in any other manner limited by a licensing or disciplinary authority in your state?  Yes  No  Cannot answer under current state law *If yes, please attach complete details.*

**AFFIX BOARD SEAL  
NOT VALID  
WITHOUT SEAL**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date