



State Medical Board of Ohio

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

MEDICAL TRAINING CERTIFICATE

Dear Doctor:

Enclosed please find an application and instructions for a medical Training Certificate. **PLEASE READ THE INSTRUCTIONS THOROUGHLY BEFORE COMPLETING THE APPLICATION.** You must complete the entire application and submit all required documentation. The application will not be deemed complete until the Ohio Medical Board has received a properly completed application form, the required fees and all supporting documentation.

IF YOU HAVE PREVIOUSLY HELD A FULL OHIO LICENSE OR CURRENTLY HOLD A TRAINING CERTIFICATE, DO NOT COMPLETE THESE FORMS. CONTACT THE MEDICAL BOARD RENEWAL DEPARTMENT AT (614) 728-3113.

Please note that, once submitted, an application cannot be withdrawn without the approval of the Medical Board.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

Upon the Medical Board's receipt of your training certificate application and appropriate fee, an acknowledgment letter will be issued to you via your training program. Once the training program has received that letter, you may participate in the training program. The acknowledgment letter will serve as proof that your application has been received by the Board and that you are legally authorized to participate in your training program while your application is being processed. The acknowledgment letter authorizes participation in the training program for 120 days. When the Board has completed processing and has approved your application, the Board will issue you a training certificate, which authorizes you to participate in your training program for the remainder of the training year. If the Board instead proposes to deny your application, you will be notified in writing of the reasons why and given an opportunity for a hearing.

HELPFUL HINTS

SAVE TIME!

REDUCE ANXIETY!

The State Medical Board of Ohio annually processes hundreds of physician applications for training certificates. In each case, the Medical Board conducts a thorough evaluation of basic medical credentials, employment or work history, and any criminal or disciplinary history. This process takes time – anywhere from a few weeks to several months, depending in large part on how quickly the applicant complies with what is requested and the nature of any problems requiring closer scrutiny.

The Ohio Medical Board will not accelerate one application at the expense of another, nor will it forego any elements of its screening process.

The following suggestions are offered to help training certificate applicants, as well as those who recruit physicians for training programs:

1. **Give the Board enough time to do its job.** The Board's issuance of an "acknowledgment letter" allows you to participate in a training program while we take the time necessary to carefully process your training certificate application.

Be aware that the process may take longer if there are items on the application about which the Board requires additional information.

2. **Send your application materials and appropriate fee to the Board as soon as possible,** in accordance with the directions in the application packet. The sooner you send them in, the sooner an acknowledgment letter can be issued.
3. **Send the verification forms to the appropriate agency or institution for completion.** If you return the forms to this Board instead of forwarding them to the appropriate agency for completion, it will only delay processing your application.
4. **Help keep the paperwork moving.** Some state licensing boards charge a fee for completing the license verification forms that are part of this training certificate application. You may save time by contacting them first and enclosing any required payment along with the verification form. State Board mailing addresses may be obtained from www.fsmb.org under "Member Services".
5. **Keep a copy of the Additional Information questions and your response for your own reference.** You must notify the Ohio Board, in writing, of any changes to the answers to these questions to ensure that they are up to date and accurate prior to a training certificate being granted to you.
6. **Immediately notify the Board, in writing, of any change in address or training programs.**

TRAINING CERTIFICATE APPLICATION CHECKLIST

This checklist is for your use and to help you determine the items you will be required to submit with your application for a training certificate. Once you file your application, status reports will be sent to you notifying you of items still needed to complete your application. **To avoid delay in the processing of your application, please read the enclosed application instructions carefully.** *Not ALL items are applicable to ALL applicants.*

ALL APPLICANTS MUST:

- Complete the **APPLICATION FOR TRAINING CERTIFICATE** including the:
 - PHYSICAL DESCRIPTION** - Attach a recent passport size COLOR photograph of yourself and complete the physical description section on page 3.
 - RESUME OF ACTIVITIES** - Be sure to list ALL activities from medical school graduation to the present time. Even if not working, indicate your activities and address for that time.
 - ADDITIONAL INFORMATION QUESTIONS (1 through 25)** - You must thoroughly explain any affirmative answers. You must also submit copies of all relevant documentation, such as court pleadings, court or agency orders, and institutional correspondence and orders.
 - AFFIDAVIT AND RELEASE OF APPLICANT** - This form must be notarized in English.
- Enclose the application fee of **\$75.00**. Make check or money order payable to **Ohio Treasurer**. *Fees are neither refundable nor transferable. DO NOT SEND CASH! (Please note: A payment in the form of a check will only be accepted from a bank in the United States.)*
- If you have changed your name due to marriage, divorce, etc. submit a copy of your name change document.
- CERTIFICATION OF TRAINING PROGRAM** - Complete the top portion of the enclosed form and forward it directly to the hospital training program director in Ohio where you will be training.
- FORM 2 - VERIFICATION OF LICENSE** - Complete the top portion of the enclosed form and forward it to each state (*other than Ohio*) and/or Canadian Province in which you hold or have held a license to practice medicine or osteopathic medicine, including a temporary license, training certificate, educational permit, or other license or certificate, *whether the license is current or not*. The licensing agency must return the form directly to this Board. Photocopies of the form may be made.
- EMPLOYER/TRAINING RECOMMENDATION FORM** - Have your employer/training program Director, within the last five years (excluding observerships, externships, and training outside of the United States), complete the Employer/Training Recommendation form. This form can be mailed or faxed back to the Board. If the employer/training program wants to substitute their own form letter for this form, please note that all information requested on the Medical Board form must be answered on the substitute form.

TO BE COMPLETED BY U.S. AND CANADIAN MEDICAL GRADUATES ONLY:

- FORM 1 - VERIFICATION OF MEDICAL EDUCATION** - Complete the top portion of the enclosed Form 1 and forward it to the appropriate institution for completion and its return directly to this Board.

TO BE COMPLETED BY INTERNATIONAL MEDICAL GRADUATES ONLY:

- ECFMG STATUS REPORT** - Request an ECFMG status report. The ECFMG status report may be ordered online at <http://www.ecfm.org/cvs/> or the paper forms must be downloaded from the ECFMG website (Publication Form 282A-SB and Payment Form 900).

or

- FORM 3 - CERTIFICATION OF ECFMG** - Complete the top portion of the enclosed form and forward it directly to the hospital in Ohio where you will be pursuing your training for completion and its return directly to this Board.

or

- VERIFICATION OF FIFTH PATHWAY PROGRAM** - If you completed a fifth pathway program the enclosed form must be completed by your fifth pathway program. Complete top portion of the form and forward directly to your fifth pathway program for completion and its return directly to this Board.

**THINGS YOU NEED TO KNOW ABOUT
THE APPLICATION PROCESS,
ACKNOWLEDGMENT LETTER AND TRAINING CERTIFICATE**

TRAINING CERTIFICATE APPLICATION PROCESS

Processing your application - The State Medical Board of Ohio annually processes thousands of applications for physician training certificates. In each case, the Board conducts a thorough evaluation of the applicant's basic medical credentials, employment history, malpractice history, and any criminal or disciplinary history. Collecting and reviewing this information takes time, depending in large part on how quickly application materials are received and the nature of any issues requiring closer scrutiny. The Board will independently seek recommendations from your previous places of training or practice as it deems appropriate. Letters of recommendation solicited and submitted by you cannot be substituted for these Board-requested recommendations.

How long does it take? - Applications are processed in the order in which they are received. An incomplete application or any unusual circumstances discovered during processing will result in a delay. You will be notified by mail via your training program if your application is incomplete or contains errors.

Upon the Medical Board's receipt of your training certificate application and appropriate fee, an acknowledgment letter will be issued to you via your training program. Once the training program has received that letter, you may participate in the training program. It takes approximately two to three weeks for the Board to issue that acknowledgment letter. The acknowledgment letter will serve as proof that your application has been received by the Board and that you are legally authorized to participate in your training program while your application is being processed.

You should receive your training certificate within 120 days from the date you begin your training program.

Application Withdrawal or Abandonment - Once submitted, an application cannot be withdrawn without the approval of the Board. However, the Board may abandon an application if the applicant fails to complete the application process within six months of initial application filing. ***Fees submitted are neither refundable nor transferable***, even if you have been permitted to withdraw your application or if you reapply after your application has been abandoned.

THE ACKNOWLEDGMENT LETTER

An acknowledgment letter is issued to you by the Board upon its receipt of your training certificate application and fee. That letter authorizes you to participate in a training program while your application is being processed. To verify that we have issued your acknowledgment letter, go to the Board's website at <http://med.ohio.gov/>. Telephone and mail verifications are no longer available from the Board offices.

If you have not received your letter within 45 days of submitting your application and fee, notify the Medical Board and your training program director immediately.

YOUR TRAINING CERTIFICATE

Limitations on your practice - Your acknowledgment letter and the training certificate you subsequently receive allow you to perform such acts as may be prescribed by or incidental to your internship, residency, or clinical fellowship program. However, you are not entitled to otherwise engage in the practice of medicine and surgery or osteopathic medicine and surgery in this state.

You must limit activities under the acknowledgment letter and training certificate to the programs of the hospitals or facilities for which the training certificate is issued. You may train only under the supervision of the physicians responsible for supervision as part of the training program.

Multi-hospital rotations - Residents and clinical fellows who rotate through multiple hospitals on a month-to-month basis as part of their training program or clinical fellowship need only apply for one training certificate during the training year.

Mid-year program changes - If you change programs at any time during the training year, you must immediately notify the Board in writing. A new application need not be completed; however, acknowledgment by the Board of receipt of a Notification of Change in Program will be required prior to your starting the new training program. Your training certificate will be valid for the remainder of the training year for which it has been issued.

Certificate renewal - A training certificate is valid for one year, but may be renewed annually at the discretion of the Board for a maximum of five years. Renewal applications are mailed on April 1st for those who initiated their training on July 1st. Others will receive their renewal application accordingly. The fee for renewal of a training certificate is currently \$35.

Revocation of a training certificate - A training certificate may be revoked by the Board upon proof satisfactory to the Board that you have engaged in practice in this state outside the scope of the internship, residency, or clinical fellowship program for which the training certificate has been issued; or upon proof satisfactory to the Board that you have engaged in unethical conduct or otherwise violated Section 4731.22, Ohio Revised Code. This and other applicable statutes and rules can be viewed on the Board's website at <http://med.ohio.gov/>.

INSTRUCTIONS FOR COMPLETING THE TRAINING CERTIFICATE APPLICATION

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 enclosed **APPLICATION FOR TRAINING CERTIFICATE** 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 to the Physical Description section in the application. Be sure to indicate the date the photograph was taken. *Black and white photographs cannot be accepted.*
3. 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).
4. Submit a check or money order for **\$75.00** made payable to **Ohio Treasurer** with your completed application. (Please note: A payment in the form of a check will **only** be accepted from a bank in the United States.) **DO NOT SEND CASH. FEES SUBMITTED ARE NEITHER REFUNDABLE NOR TRANSFERABLE.**
5. Certification of Training Program
Complete the top portion of the enclosed form and forward it directly to the hospital training program director in Ohio where you will be training. **Please note that faxed copies will not be accepted.**
6. Verification of License (Form 2)
Complete the top portion and forward the enclosed Verification of License (Form 2) and forward it to each state and/or Canadian Province in which you hold or have held a license to practice medicine or osteopathic medicine, including a temporary license, training certificate, educational permit, or other license or certificate, **whether the license is current or not**. That licensing board must return the form directly to the Ohio Medical Board. Photocopies of the form may be made. Since some state boards charge a fee for completion of this form, you may wish to check with each board before submitting this form to them. State Board mailing addresses may be obtained from www.fsmb.org under "Member Services". **Please note that faxed copies will not be accepted.**

SECTION 7 TO BE COMPLETED BY US AND CANADIAN GRADUATES ONLY

7. Verification of Medical Education

Form 1

If you are a graduate of a school located ***in the United States or Canada***, complete the top portion of the enclosed Form 1 and forward to your medical/osteopathic school of graduation for completion and its return directly to this Board. ***If you have not yet graduated have your medical school complete the form after graduation.*** If you attended more than one medical/osteopathic school, you must have each and every medical/osteopathic school of attendance complete the Verification of Medical Education form. Photocopies of the form may be made. ***Please note that faxed copies will not be accepted. In addition, copies of diplomas and/or transcripts will not be accepted in lieu of the verification form.***

SECTION 8 & 9 TO BE COMPLETED BY INTERNATIONAL MEDICAL SCHOOL GRADUATES ONLY

8. ECFMG Status Report

If you are a graduate of a medical school located **outside the United States or Canada**, request a status report be sent directly from ECFMG. The ECFMG status report may be ordered online at <http://www.ecfm.org/cvs/> or the paper forms must be downloaded from the ECFMG website (Publication Form 282A-SB and Payment Form 900). ***Please note that faxed copies of the status report will not be accepted. In addition, copies of the ECFMG certificate will not be accepted in lieu of the status report.***

or

Form 3

If the hospital in Ohio in which you are pursuing your training obtains verification directly from ECFMG, complete the top portion of Form 3 and forward it to your hospital training program for completion and its return directly to this Board. ***Please note that faxed copies will not be accepted.***

9. Fifth Pathway Program

If you are a graduate of a school located **outside the United States or Canada**, and you completed a fifth pathway program, complete the enclosed Verification of Fifth Pathway Program form and forward it directly to the medical school where you completed your training for completion and its return directly to this Board. ***Please note that faxed copies will not be accepted. In addition, copies of the certificate will not be accepted in lieu of the verification form.***

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.



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 TRAINING CERTIFICATE

PLEASE TYPE OR PRINT CLEARLY

NOTE: Application fee is \$75.00. Fees submitted are neither refundable nor transferable.

PERSONAL INFORMATION

Check only one: MD DO

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:

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)

Physicians Address (Be sure to notify the Board of any change in address):
Number & Street
City State Zip Code Country

TRAINING PROGRAM INFORMATION

Ohio Training Program Address (Hospital in Ohio where you will be starting your training):
Hospital & Department
Number & Street
City State Zip Code

Dates of Training: Beginning Date: Mo/Day/Yr / / Ending Date: Mo/Day/Yr / /

J-1 and H-1B VISA

To be completed by International medical school graduates only:

Are you currently applying for a J-1 or an H-1B Visa? YES NO
If YES check which one? J-1 H-1B

MEDICAL OR OSTEOPATHIC EDUCATION

Medical or
 Osteopathic
 School of
 Graduation:

School Name		
City	State	Country

Dates
 Attended:

From:

 To:

Degree
 Received:

	Date Received <table border="1" style="display: inline-table; text-align: center; width: 100px; height: 25px;">Mo/Day/Yr / /</table>
--	---

Other
 Medical or
 Osteopathic
 Schools
 Attended
 (If none,
 enter
 "NONE")

School Name		
City	State	Country

Dates
 Attended:

From:

 To:

Reason degree not
 received at this school:

--

FIFTH PATHWAY PROGRAM

Fifth
 Pathway
 Program
 (if none,
 enter
 "NONE"):

Hospital or Institution		
Name of Medical School		
City	State	Country

Dates
 Attended:

From:

 To:

ECFMG CERTIFICATE

To be completed by International medical school graduates only:

Do you have a valid ECFMG certificate? YES NO

Number: _____ Date Issued:

 Expires:

Applicant Name: _____ Date: _____

PHYSICAL DESCRIPTION

Staple a recent (taken within the last six months) passport-type **COLOR** photograph of applicant in the space provided below. Black and white photographs cannot be accepted.

Birth Date:

Mo/Day/Yr / /

Birth Place:

City	State	Country
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Gender:

<input type="checkbox"/> Male	<input type="checkbox"/> Female	For statistics only (optional)
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<u>STAPLE</u>
<u>COLOR</u>
<u>PASSPORT SIZE</u>
<u>PHOTOGRAPH</u>
<u>HERE</u>
Photograph must have been taken within last six months (Black and white photos cannot be accepted)

PHYSICAL DESCRIPTION
Height _____
Weight _____
Hair Color _____
Eye Color _____
Identifying Marks _____

Date Photo Taken: _____ / _____ / _____
 mo/yr

LICENSES IN THE UNITED STATES & CANADA

List ALL states/provinces, whether the license is current or not, in which you are or have been licensed, including temporary, educational permits, limited licenses, etc., to practice medicine and surgery or osteopathic medicine and surgery. Indicate license number, date of issuance and the type of license. If additional space is needed, attach an extra sheet. (If none, enter "NONE") **A Form 2, Verification of License form must be sent to each state listed.**

STATE/PROVINCE	ISSUE DATE	LICENSE #	TYPE OF LICENSE	LICENSE CURRENT
	<i>MO/YR</i>		<i>✓ ONLY ONE</i>	<i>✓ ONLY ONE</i>
			<input type="checkbox"/> Full, unrestricted <input type="checkbox"/> Temporary <input type="checkbox"/> Educational <input type="checkbox"/> Limited <input type="checkbox"/> Other: _____ <i>(please specify)</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO Expiration Date: _____
			<input type="checkbox"/> Full, unrestricted <input type="checkbox"/> Temporary <input type="checkbox"/> Educational <input type="checkbox"/> Limited <input type="checkbox"/> Other: _____ <i>(please specify)</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO Expiration Date: _____
			<input type="checkbox"/> Full, unrestricted <input type="checkbox"/> Temporary <input type="checkbox"/> Educational <input type="checkbox"/> Limited <input type="checkbox"/> Other: _____ <i>(please specify)</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO Expiration Date: _____

Applicant Name: _____ Date: _____

TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE RESUME OF ACTIVITIES

List ALL activities in chronological order from the date of medical school 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", and indicate your permanent home address for that time period. 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.

Check here if you are a new graduate (within 3 months). You DO NOT need to complete this form.

From _____ /_____ Month/Year	Hospital/University name, Other or non-working activity	Position & Department	%Clinical
To _____ /_____ Month/Year	Complete Number & Street Address		%Admin.
	City _____ State/Country _____ Zip Code _____		

From _____ /_____ Month/Year	Hospital/University name, Other or non-working activity	Position & Department	%Clinical
To _____ /_____ Month/Year	Complete Number & Street Address		%Admin.
	City _____ State/Country _____ Zip Code _____		

From _____ /_____ Month/Year	Hospital/University name, Other or non-working activity	Position & Department	%Clinical
To _____ /_____ Month/Year	Complete Number & Street Address		%Admin.
	City _____ State/Country _____ Zip Code _____		

From _____ /_____ Month/Year	Hospital/University name, Other or non-working activity	Position & Department	%Clinical
To _____ /_____ Month/Year	Complete Number & Street Address		%Admin.
	City _____ State/Country _____ Zip Code _____		

From _____ /_____ Month/Year	Hospital/University name, Other or non-working activity	Position & Department	%Clinical
To _____ /_____ Month/Year	Complete Number & Street Address		%Admin.
	City _____ State/Country _____ Zip Code _____		

Applicant Name: _____

Date: _____

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Training Certificate – Medicine or Osteopathic Medicine – Resume of Activities
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From _____ /_____ Month/Year	Hospital/University name, Other or non-working activity	Position & Department	%Clinical
To _____ /_____ Month/Year	Complete Number & Street Address		%Admin.
	City _____ State/Country _____ Zip Code _____		

From _____ /_____ Month/Year	Hospital/University name, Other or non-working activity	Position & Department	%Clinical
To _____ /_____ Month/Year	Complete Number & Street Address		%Admin.
	City _____ State/Country _____ Zip Code _____		

From _____ /_____ Month/Year	Hospital/University name, Other or non-working activity	Position & Department	%Clinical
To _____ /_____ Month/Year	Complete Number & Street Address		%Admin.
	City _____ State/Country _____ Zip Code _____		

From _____ /_____ Month/Year	Hospital/University name, Other or non-working activity	Position & Department	%Clinical
To _____ /_____ Month/Year	Complete Number & Street Address		%Admin.
	City _____ State/Country _____ Zip Code _____		

From _____ /_____ Month/Year	Hospital/University name, Other or non-working activity	Position & Department	%Clinical
To _____ /_____ Month/Year	Complete Number & Street Address		%Admin.
	City _____ State/Country _____ Zip Code _____		

From _____ /_____ Month/Year	Hospital/University name, Other or non-working activity	Position & Department	%Clinical
To _____ /_____ Month/Year	Complete Number & Street Address		%Admin.
	City _____ State/Country _____ Zip Code _____		

Applicant Name: _____

Date: _____

**TRAINING 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 (DO NOT write explanations on these pages)**. 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)

	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: _____

- | | 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 pled guilty to, been 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 or 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)? Please be advised that you are required to submit copies of all relevant documentation, such as police reports, certified court records and any institutional correspondence and orders. Photocopies will not be accepted. If case has been expunged you must submit certified letter from court. | <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"/> |

- | | 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 limitations 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"/> |
|--|--------------------------|--------------------------|

“*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 limitations 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: _____

**TRAINING CERTIFICATE – MEDICINE OR OSTEOPATHIC MEDICINE
CRIMINAL OFFENSE INFORMATION**

This form must be completed if you have responded yes to Additional Information Question #15 or #16. *Make additional copies of this form as needed.*

Name of Applicant (print clearly): _____

OFFENSE INFORMATION:

Date of Incident: _____

Location of Incident: _____
City State

Were you arrested: Yes No

If the incident was alcohol-related, did you submit to a breath, blood, urine or other test to determine the amount of alcohol in your body: Yes No

If yes, type of test and result: _____

What offense(s) were you charged with: _____

Were the charges amended: Yes No

If yes, what were the final charges: _____

DISPOSITION: Pending Charges Dismissed Charges Dropped
 Plea: _____ Other: _____
Specify Specify

You must provide a detailed written explanation of the event including a description of the event, what led up to the event and what was learned. This must be described in your own words. Do not reference attached documentation. If additional space is needed, attach a separate sheet. Submit certified copies of the police report/arrest record, a copy of the charges or ticket, a copy of the final court disposition and any other relevant documentation.

Applicant Signature _____

Date _____

**TRAINING 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 _____

**TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE
AFFIDAVIT AND RELEASE OF APPLICANT**

The affidavit and release MUST be completed by ALL applicants. The form must be notarized in English. 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 training 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 further state that by filing this application for a training 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 practice of medicine or osteopathic medicine. 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 training 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 licensure 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 training 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 licensure or practice thereunder.

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 I must limit my activities under the certificate to the programs of the hospitals or facilities for which the training certificate is issued; and that I may train only under the supervision of the physicians responsible for supervision as part of the internship, residency, or clinical fellowship program.

I further understand that issuance of a training certificate in the State of 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 denial 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

THIS FORM CANNOT BE FAXED



State Medical Board of Ohio

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TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE CERTIFICATION OF TRAINING PROGRAM

I am applying for a training certificate in the State of Ohio. The State Medical Board of Ohio requires that this form be completed by the Ohio training program in which I will be training. Please complete the form and return it directly to the State Medical Board of Ohio at the above address.

THIS SECTION TO BE COMPLETED BY APPLICANT

Name of Applicant: _____
Last First Middle Suffix (Jr., II)

THIS SECTION TO BE COMPLETED BY OHIO TRAINING PROGRAM

Name of Training Program: _____

Training Program Address: _____
Street Address

City State Zip Code

Type of Program (check only one): Intern Resident Clinical Fellow

Specialty
(see reverse side):

CERTIFICATION DATES - Indicate the month, day and year for both the beginning and ending dates in which the training certificate is to be issued. **THE DATES ARE NOT TO EXCEED ONE YEAR.** If the application is received prior to the date of the appointment, the appointment date will be used. If the application is received after the appointment date, or is not completed until after the appointment date, the completion date will be the date the certificate will become effective.

Dates of Training
(not to exceed
one year):

Beginning Date:

MO/DAY/YR
/ /

Ending Date:

MO/DAY/YR
/ /

I hereby certify that I have checked the credentials of the above applicant, that the statements, as completed, are true to the best of my knowledge and he/she is of good moral character. I further certify that he/she will limit his/her practice and training within the physical confines of the hospital, or facilities for which the training certificate to practice is sought and that he/she will practice only under the supervision of the attending medical staff of such hospital or facility for which the training certificate to practice is granted. I hereby recommend that the above applicant be granted the certificate herein applied for.

**HOSPITAL
SEAL**

**(If hospital has no
seal, indicate and
have form notarized)**

Signature of Medical Director or Program Director

Name (please print)

Date

THIS FORM CANNOT BE FAXED

SPECIALTIES

DESCRIPTION

Abdominal Surgery
 Addiction Medicine
 Addiction Psychiatry
 Adolescent Medicine (Internal Med)
 Adolescent Medicine (Pediatrics)
 Adult Reconstructive Orthopedics
 Aerospace Medicine
 Allergy
 Allergy & Immunology
 Anatomic/Clinical Pathology
 Anatomic Pathology
 Anesthesiology
 Blood Banking/Transfusion Med
 Clinical Cardiac Electrophysiology
 Cardiothoracic Surgery
 Cardiovascular Diseases
 Chemical Pathology
 Child and Adolescent Psychiatry
 Child Neurology
 Clinical Biochemical Genetics
 Clinical Cytogenetics
 Clinical Genetics
 Clinical Laboratory Immunology (All & Imm)
 Clinical & Lab. Dermatological Imm
 Clinical & Lab. Immunology (Int. Med)
 Clinical & Lab. Immunology (Peds)
 Clinical Molecular Genetics
 Clinical Neurophysiology
 Clinical Pathology
 Clinical Pharmacology
 Colon & Rectal Surgery
 Critical Care Med (Anesthesiology)
 Critical Care Medicine (Int Med)
 Critical Care Medicine (Neuro Surg)
 Critical Care Medicine (OB-GYN)
 Cytopathology
 Dermatology
 Dermatopathology (Pathology)
 Dermatopathology (Dermatology)
 Dermatologic Surgery
 Developmental-Behavioral Pediatrics
 Diabetes
 Diagnostic Radiology
 Emergency Medicine
 Endocrinology, Diabetes & Metabolism
 Epidemiology
 Facial Plastic Surgery
 Family Practice
 Foot & Ankle, Orthopedics
 Forensic Pathology
 Forensic Psychiatry
 Gastroenterology
 General Practice

DESCRIPTION

General Preventive Medicine
 General Surgery
 Geriatric Medicine (Family Practice)
 Geriatric Medicine (Internal Med)
 Geriatric Psychiatry
 Gynecology
 Gynecological Oncology
 Hand Surgery (Ortho Surgery)
 Hand Surgery (Plastic Surgery)
 Head & Neck Surgery
 Hematology (Internal Medicine)
 Hematology (Pathology)
 Hematology/Oncology
 Hepatology
 Immunology
 Immunopathology
 Infectious Diseases
 Internal Medicine
 Internal Medicine/Pediatrics
 Legal Medicine
 Maternal & Fetal Medicine
 Maxillofacial Radiology
 Medical Genetics
 Medical Management
 Medical Microbiology
 Medical Oncology
 Medical Toxicology (Emer Med)
 Medical Toxicology (Pediatrics)
 Medical Toxicology (Prevent. Med)
 Musculoskeletal Oncology
 Neonatal-Perinatal Medicine
 Nephrology
 Neurology
 Neurology/Diagnostic Rad/Neuroradiology
 Neurological Surgery
 Neuropathology
 Neuroradiology
 Nuclear Medicine
 Nuclear Radiology
 Nutrition
 Obstetrics
 Obstetrics & Gynecology
 Occupational Medicine
 Ophthalmology
 Orthopedic Surgery
 Orthopedic Surgery of the Spine
 Orthopedic Trauma
 Osteopathic Manipulative Medicine
 Otolaryngology
 Otology/Neurotology
 Pain Management (Anesthesiology)
 Pain Medicine
 Palliative Medicine

DESCRIPTION

Pediatric Allergy
 Pediatric Cardiology
 Pediatric Critical Care Medicine
 Pediatric Emergency Med (Emer Med)
 Pediatric Emergency Med (Peds)
 Pediatric Endocrinology
 Pediatric Gastroenterology
 Pediatric Hematology/Oncology
 Pediatric Infectious Disease
 Pediatric Nephrology
 Pediatric Ophthalmology
 Pediatric Orthopedics
 Pediatric Otolaryngology
 Pediatric Pathology
 Pediatric Pulmonology
 Pediatric Radiology
 Pediatric Rheumatology
 Pediatric Surgery (Neurology)
 Pediatric Surgery (Surgery)
 Pediatric Urology
 Pediatrics
 Physical Medicine & Rehabilitation
 Plastic Surgery
 Proctology
 Psychiatry
 Psychoanalysis
 Public Health & Gen Preventive Med
 Pulmonary Critical Care Medicine
 Pulmonary Disease
 Radiation Oncology
 Radiological Physics
 Radiology
 Radioisotopic Pathology
 Reproductive Endocrinology
 Rheumatology
 Selective Pathology
 Sleep Medicine
 Spinal Cord Injury
 Sports Medicine (Emer Med)
 Sports Medicine (Family Practice)
 Sports Medicine (Internal Med)
 Sports Medicine (Ortho Surgery)
 Sports Medicine (Pediatrics)
 Surgical Critical Care (Surgery)
 Surgical Oncology
 Thoracic Surgery
 Trauma Surgery
 Transplant Surgery
 Undersea Medicine
 Urology
 Vascular & Interventional Radiology
 Vascular Surgery
 Other (i.e., specialty other than those listed)
 Unspecified



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**TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE
FORM 1 - VERIFICATION OF MEDICAL EDUCATION
TO BE COMPLETED BY LCME OR AOA ACCREDITED SCHOOLS ONLY**

THIS FORM IS NOT TO BE COMPLETED PRIOR TO GRADUATION

I am applying for a training certificate in the State of Ohio. The State Medical Board of Ohio requires that this form be completed by any medical or osteopathic schools I have attended. Please complete this form and return it *directly* to the State Medical Board of Ohio at the above address.

THIS SECTION TO BE COMPLETED BY APPLICANT

Full Name: _____
Last First Middle Suffix (Jr., II)

Name of Medical/Osteopathic School: _____

Location: _____
City State

I hereby authorize the above named medical/osteopathic school to furnish the information below to the State Medical Board of Ohio.

Signature of Applicant

Date

THIS SECTION TO BE COMPLETED BY MEDICAL OR OSTEOPATHIC SCHOOL

Our records indicate that _____
Last First Middle Suffix (Jr., II)
attended medical/osteopathic school From: ____/____/____ To: ____/____/____
month/year month/year

This individual (*check one*):

- was awarded the degree of _____ on ____/____/____
month/day/year
- was not awarded a degree (please attach an explanation)

I, certify that the above information is an accurate account of the above named individual's official records maintained and is true and correct to my knowledge.

**AFFIX
INSTITUTIONAL
SEAL**

(If your institution does not have an official seal, please indicate and have form notarized)

Signature

Name (please print)

Title

Date

THIS FORM CANNOT BE FAXED



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TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE FORM 2 - VERIFICATION OF LICENSE

I am applying for a training certificate in the State of Ohio. The State Medical Board of Ohio requires that this form be completed by each state or Canadian Province 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 at the above address.

THIS SECTION TO BE COMPLETED BY APPLICANT

Full Name: _____
Last First Middle Suffix (Jr., II)

License Number: _____ Date of Birth: _____
month/day/year

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

THIS SECTION TO BE COMPLETED BY STATE BOARD OR CANADIAN PROVINCE

State/Province: _____

Name of Licensee: _____
Last First Middle Suffix (Jr., II)

License Number: _____ Issue Date: _____ Expire(d): _____
month/day/year month/day/year

License Type: full, unrestricted temporary training certificate
 educational limited permit other: _____
(please specify)

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

THIS FORM CANNOT BE FAXED



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TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE FORM 3 - CERTIFICATION OF ECFMG GRADUATES OF SCHOOLS LOCATED OUTSIDE THE UNITED STATES OR CANADA ONLY

Instructions to Hospital Training Program: If you receive verification of ECFMG status directly from ECFMG, please complete the form below and return directly to the State Medical Board of Ohio at the above address. **You must also attach a copy of the applicant's ECFMG status report.**

THIS SECTION TO BE COMPLETED BY APPLICANT

Name: _____
Last First Middle Suffix (Jr., II)

ECFMG Certificate Number: _____ Expiration Date: _____

THIS SECTION TO BE COMPLETED BY OHIO TRAINING PROGRAM

Name of Training Program: _____

Training Program Address: _____

Street Address

Department

City

State

Zip Code

I hereby CERTIFY that I received verification of the ECFMG status report for the above-named applicant, directly from ECFMG. I have attached a copy of the ECFMG status report.

HOSPITAL SEAL

(If hospital has no seal, indicate and have form notarized)

Signature of Medical Director or Program Director

Name (please print)

Date

THIS FORM CANNOT BE FAXED



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TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE VERIFICATION OF FIFTH PATHWAY PROGRAM

I am applying for a training certificate in the State of Ohio. The State Medical Board of Ohio requires that this form be completed by my Fifth Pathway program. Please complete the form and return it *directly* to the State Medical Board of Ohio at the above address.

THIS SECTION TO BE COMPLETED BY APPLICANT

Name: _____
Last First Middle Suffix (Jr., II)

Fifth Pathway Program: _____

Medical/Osteopathic School: _____

I hereby authorize my fifth pathway program to furnish the information below to the State Medical Board of Ohio.

Signature of Applicant Date

THIS SECTION TO BE COMPLETED BY MEDICAL SCHOOL

This certifies that _____ has completed a Fifth Pathway program at
(name of applicant)

_____ affiliated
(name of hospital or institution)

with _____
(name of medical school)

located in _____
City State Country

which is approved by the Liaison Committee on Medical Education. The above-named applicant's duties

were discharged from _____ to _____
(month/day/year) (month/day/year)

**MEDICAL SCHOOL
SEAL**

**(If school has no seal,
indicate and have
form notarized)**

Signature of Dean or Director
(Original signatures only, name stamps will not be accepted)

Name (please print or type)

Position

Telephone Number (include area code)

THIS FORM CANNOT BE FAXED



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EMPLOYER/TRAINING PROGRAM RECOMMENDATION FORM

Dr. _____
(Please provide the applicant's first and last name.)

is applying for a training certificate in the State of Ohio. We would appreciate your assistance in filling out the following evaluation so that we can process his/her application for the training certificate. **To ensure processing of the physicians application please complete and return this form to the State Medical Board of Ohio at the above address, within two (2) weeks. The form can also be faxed to the Board at (614) 466-4331.** Your immediate attention to this matter will be greatly appreciated by the applicant as well as by us. Information provided is considered confidential under Section 149.43(A)(2)(a), Ohio Revised Code. Thank you for your time and assistance.

- (1) How long have you known him/her? _____
- (2) What is/was your supervisory capacity? _____
- (3) At what hospital? _____
- (4) How would you rate his/her medical knowledge and techniques? _____
- (5) In your opinion is he/she a person of good moral and ethical character? _____
- (6) Does he/she work well with peers and medical staff? _____
- (7) Does he/she relate well to patients? _____
- (8) How is his/her command of the English language (if applicable)? _____
- (9) Would you recommend him/her for a training certificate to participate in a training program in Ohio? _____

Additional comments, please: (if needed, an extra sheet of paper may be used)

Sincerely,

Gina Bouldware
Licensure Examiner

Signature of Physician

Name of Physician (please type or print clearly)

Position

Telephone number (include area code)

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