State Medical Board of Ohio

30 E. Broad St., 3rd Floor
Columbus, Ohio 43215
(614) 466-3934
www.med.ohio.gov

Allied Health Professional Application
Verification of State License

I am applying for a license to practice as an Allied Health Professional 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 licenses in the healthcare field, whether current or not. Please complete the form and return it directly to the State Medical Board of Ohio at the above address.

To Be Completed By The Applicant

Name	Last	First	Middle	Suffix (Jr., II)
Current Address	Number & Street		License Number	
	City	State Zip	Date of Birth	Month / Day / Year / /
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.

To Be Completed By State Board or Canadian Province

State					
Name of Licensee	Last	First	Middle		Suffix (Jr., II)
License Number		Issue Date	Month / Day / Year / /	License Current? If not, Please Explain	☐ Yes ☐ No

	Yes	No	Cannot answer under current state law
Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state?	☐	☐	☐
Have formal disciplinary proceedings been initiated against applicant's license by a disciplinary authority in your state?	☐	☐	☐
Has the applicant ever been warned, censured or in any other manner disciplined or has applicant's license been revoked, suspended, or in any other manner limited by a licensing or disciplinary authority in your state?	☐	☐	☐

If yes, please attach complete details.

AFFIX BOARD SEAL HERE
NOT VALID WITHOUT SEAL

_____
Signature

_____
Title

_____
Date

Return Completed Form To The State Medical Board of Ohio at The Above Address.