State Medical Board of Ohio
30 East Broad Street, 3rd Floor
Columbus, OH 43215
med.ohio.gov

PODIATRIC MEDICINE LICENSE APPLICATION

Post Graduate Training Certification

Hospital/Training Institution: Email completed forms directly to med.license@med.ohio.gov.

THIS SECTION TO BE COMPLETED BY APPLICANT

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

Name of School: _____

Location: _____
Address City State Zip Code

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

_____ _____
Signature of Applicant Date

THIS SECTION TO BE COMPLETED BY HOSPITAL/TRAINING INSTITUTION

Our records indicate that: _____
Last First Middle Suffix (Jr., II)

Participated in our training program from _____ to _____
month/year *month/year*

Type of Program: ☐ Intern ☐ Resident ☐ Clinical Fellow

Specialty: _____

This individual *(check one):*
☐ was awarded a certificate on _____ ☐ was NOT awarded a degree (attach explanation)
month/day/year

Was the training accredited by the Council on Podiatric Medical Education? ☐ Yes ☐ No

Please offer the following information in support of the above-named individual's application for licensure; circle or highlight your selection:

	Poor				Acceptable				Excellent	
Medical knowledge and techniques	1	2	3	4	5	6	7	8	9	10
Relationship with patients	1	2	3	4	5	6	7	8	9	10
Ability to work well with peers and medical staff	1	2	3	4	5	6	7	8	9	10
Command of the English language	1	2	3	4	5	6	7	8	9	10

Additional comments: _____

I certify that the above information is an accurate account of the above-named individual's official records and is true and correct to my knowledge. Therefore, I recommend the applicant for a certificate to practice podiatry in the State of Ohio.

_____ _____
Name Title

_____ _____
Signature Date

_____ _____
Phone Number Email