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

SPECIAL ACTIVITY CERTIFICATE APPLICATION
Verification of Activity

Email completed form directly to the State Medical Board at certificates@med.ohio.gov.

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

Will be performing the special activity outlined below in accordance with Ohio Revised Code 4731.294 with

Hospital/Institution: _____

_____
Hospital Street Address City State Zip Code

effective from _____ to _____ *Date range may **not** exceed 30 days.
Month/Day/Year Month/Day/Year

Description of special activity:

I hereby certify that the information contained herein is true, accurate and complete to the best of my knowledge, information and belief.

_____ _____
Signature Date

_____ _____
Name Title

_____ _____
Email Phone

06/2017