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

VISITING CLINICAL PROFESSIONAL DEVELOPMENT CERTIFICATE APPLICATION
Verification of Activity

This form must be completed and signed by the Dean of the Medical School or the Department Director or Chairperson of the hospital conducting the program. Indicate the dates of appointment. Include supporting documentation that applicant: (1) has sufficient financial resources to support applicant and any dependents based on the cost of living in the geographic area of the school or hospital conducting the program, including room, board, transportation and related living expenses; (2) has professional liability insurance provided by the program or the school or hospital conducting the program for the duration of the applicant's participation in the program; and (3) is qualified to participate in the visiting clinical professional development program and will be permitted to work only as part of the clinical professional development program and only under the direct supervision of a qualified faculty member of the school or hospital conducting the program who holds a current, unrestricted license to practice medicine and surgery or osteopathic medicine and surgery in the State of Ohio. Email completed form directly to the State Medical Board at certificates@med.ohio.gov.

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

has been accepted for participation in a clinical professional development program at:

Medical School: _____

Address: _____
Number/Street City State Zip Code

effective from _____ to _____ *Date range may **not** exceed one year.
Month/Day/Year Month/Day/Year

This program is affiliated with the following teaching hospital(s):

Name of Teaching Hospital (include address)	Signature of Hospital/Medical Director (print name legibly beneath)		Date
	Signature		
	Print name legibly		
	Signature		
	Print name legibly		
	Signature		
	Print name legibly		
	Signature		
	Print name legibly		

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Applicant shall perform the following medical or surgical activities as part of applicant's participation in a clinical professional development program in accordance with Ohio Revised Code 4731.298.

Description of Activity:

Type of Practice:

Type of Patient Contact:

Type of Supervision:

List of Procedures to Be Learned:

List of Patient-Based Research Projects:

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Reason Advanced Training Needed:

Benefits to Home Country:

The above-named applicant:

☐ will ☐ will NOT act as a consultant to an Ohio licensed physician.

I hereby certify that the information contained herein is true, accurate and complete to the best of my knowledge, information and belief. I further certify that the applicant has sufficient financial resources to support the applicant and any dependents based on the cost of living in the geographic area of the school or hospital conducting the program, including room, board, transportation and related living expenses. I further certify that applicant has professional liability insurance provided by the program or the school or hospital conducting the program for the duration of the applicant's participation in the program. I further certify that applicant will not write orders or prescribe medication, bill for services performed, occupy a residency or fellowship position approved by the accreditation council for graduate medical education, or attempt to have participation in the clinical professional development program counted toward meeting graduate medical education requirements. I further certify that applicant meets the eligibility requirements of this certificate and will be permitted to work only as part of the clinical professional development program and only under the direct supervision of a qualified faculty member of the school or teaching hospital conducting the program who holds a current, unrestricted license in the State of Ohio.

Name (dean, department director or chairperson) _____ Title _____

Signature _____ Date _____

Phone Number _____ Email _____