State Medical Board of Ohio
30 East Broad Street, 3rd Floor
Columbus, OH 43215
(614) 466-3934 med.ohio.gov

TRAINING CERTIFICATE APPLICATION

Fifth Pathway Program Verification

Schools: Email completed forms directly to certificates@med.ohio.gov.

THIS SECTION TO BE COMPLETED BY APPLICANT

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

Fifth pathway program: _____

Name of medical 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 _____
Name of Applicant

has completed a Fifth Pathway Program at _____
Hospital or Institution

affiliated with _____
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/year month/year

_____ _____
Name of Dean or Director Title

_____ _____
Signature Date

_____ _____
Phone Number Email