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

TRAINING CERTIFICATE APPLICATION

Medical Education Verification

Do not complete this form prior to graduation
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)

Name of MD, DO or DPM School: _____

Location: _____
City State

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

_____ _____
Signature of Applicant Date

THIS SECTION TO BE COMPLETED BY MEDICAL, OSTEOPATHIC or PODIATRIC SCHOOL

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

Attended medical/osteopathic/podiatric school from _____ to _____
month/year month/year

This individual *(check one):*

☐ was awarded the degree of _____ on _____
month/day/year

☐ was not awarded a degree (please attach an explanation)

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.

_____ _____
Name Title

_____ _____
Signature Date

_____ _____
Phone Number Email