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

TRAINING CERTIFICATE

Training Program Change Form

Program: Email completed form directly to certificates@med.ohio.gov.

THIS SECTION TO BE COMPLETED BY APPLICANT

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

Ohio Training Certificate Number: _____

THIS SECTION TO BE COMPLETED BY THE NEW TRAINING PROGRAM

Name of Training Program: _____

Training Program Address: _____
Street Address

_____
City State Zip Code

Type of Program (check only one): ☐ Intern ☐ Resident ☐ Clinical Fellow

Specialty: _____

CERTIFICATION DATES - Indicate the month, day and year for both the beginning and ending dates in which the training certificate is to be issued. DATE RANGE CANNOT EXCEED ONE YEAR. If the application is received prior to the date of the appointment, the appointment date will be used. If the application is received after the appointment date, or is not completed until after the appointment date, the completion date will be the date the certificate will become effective.

Beginning Date: _____ Ending Date: _____
Month/Day/Year Month/Day/Year

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 of Medical/Program Director Title

_____ _____
Signature Date

_____ _____
Phone Number Email