State Medical Board of Ohio

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

TRAINING CERTIFICATE - Medicine or Osteopathic Medicine

Training Program Certification

Program: Complete this form and email directly to certificates@med.ohio.gov.

Applicant's Full Name: ____
Last First Middle Suffix (Jr., II)

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 three years. 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, a new form will be required.

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 or Program Director Title

______________________________ ______________________________
Signature Date

______________________________ ______________________________
Phone Number Email