

State Medical Board of Ohio

med.ohio.gov

30 E. Broad St., 3rd Floor · Columbus, OH 43215-6127 · (614) 466-3934

Ohio Physician Licensure Application

1. **Indicate License Type** M.D. D.O. M.D. Telemedicine D.O. Telemedicine

2. **Name: Indicate your full legal name. Please list any maiden names or other names used.**

Last	First	Middle	Suffix
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Maiden Name	All other names used		
<input type="text"/>	<input type="text"/>		

3. **Contact Information: Please complete all sections**

Indicate which address you wish to use for mailings from the Medical Board. Practice Address Home Address

Practice Address

Street 1	<input type="text"/>	Phone Number	<input type="text"/>
Street 2	<input type="text"/>	Fax Number	<input type="text"/>
City	<input type="text"/>	State	<input type="text"/>
Zip Code	<input type="text"/>	email	<input type="text"/>

Home Address

Street 1	<input type="text"/>	Phone Number	<input type="text"/>
Street 2	<input type="text"/>	Fax Number	<input type="text"/>
City	<input type="text"/>	State	<input type="text"/>
Zip Code	<input type="text"/>	email	<input type="text"/>

4. **Identification**

Date of birth	Birth City	State	Country
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
SSN	Gender		
<input type="text"/>	<input type="radio"/> Male <input type="radio"/> Female		

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. §1320a-7e(b), 5 U.S.C. §552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. §666 and §3123.50, O.R.C.). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. §11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with Chapters 4730., 4731., 4760., 4762., or 4778. O.R.C. or as otherwise required by state or federal law.

5. Preliminary Education.

High School or equivalent:

City State Country

Date From Date To

Undergraduate College 1

City State Country

Date From Date To Degree

Undergraduate College 2

City State Country

Date From Date To Degree

6. TOEFL- IBT. This section is only required to be completed by International Medical School Graduates.

The TOEFL, TWE, ECFMG's ENGLISH EXAM (PRIOR TO 7/1/98), ETC., ARE NOT EQUIVALENT AND CANNOT BE SUBSTITUTED FOR THE TOEFL-IBT.

Graduates of medical schools located outside the United States and Canada must achieve a score of at least 26 in Speaking and 26 in Listening with a total score of 90 on the TOEFL-IBT, regardless of citizenship or country of birth. Prior to July 2006 the Test of Spoken English was required with a minimum score of 40 (between 7/95 and 7/06) or 230 (prior to 7/95). The following are the only exceptions permitted under Ohio law:

- YES NO Have you completed two years of undergraduate college work in the United States?
- YES NO During the five years immediately preceding the date of your application have you:
Held a current medical license (i.e., unrestricted, training certificate, educational permit) in the United States **AND** Have you been actively practicing medicine (graduate medical education is included) in the United States?
- YES NO Have you completed a Fifth Pathway program?
- YES NO Have you passed the Clinical Skills Assessment exam given by the ECFMG on or after July 1, 1998?

If you answered 'NO' to all of the above, you are required to take the TOEFL-IBT. Please refer to the instructions for information on contacting the Educational Testing Service. The Board cannot waive this requirement.

7. Ohio Training Program.

- YES NO Are you or will you be in an accredited training program in Ohio? If yes, please identify the program below.

Program Name

8. Military.

- YES NO Are you currently in the United States Military or Reserves or a Military Veteran?
- YES NO Are you the spouse of an individual currently serving in the United States Military or Reserves?

9. Medical School: List all medical schools you have attended, including those from which you did not graduate in chronological order. Attach an additional sheet if necessary.

1. School Name	<input type="text"/>	Date From	<input type="text"/>
Address	<input type="text"/>	Date To	<input type="text"/>
City	<input type="text"/>	State	<input type="text"/>
		Zip Code	<input type="text"/>
Country	<input type="text"/>	Graduation Date	<input type="text"/>
		Degree	<input type="text"/>

2. School Name	<input type="text"/>	Date From	<input type="text"/>
Address	<input type="text"/>	Date To	<input type="text"/>
City	<input type="text"/>	State	<input type="text"/>
		Zip Code	<input type="text"/>
Country	<input type="text"/>	Graduation Date	<input type="text"/>
		Degree	<input type="text"/>

10. Postgraduate Training: List all postgraduate programs you have attended, including those you did not complete. Copy and attach additional pages if necessary.

1. Hospital Name	<input type="text"/>	Date From	<input type="text"/>
Address	<input type="text"/>	Date To	<input type="text"/>
City	<input type="text"/>	State	<input type="text"/>
		Zip Code	<input type="text"/>
Country	<input type="text"/>		
Department/Specialty:	<input type="text"/>	Successfully Completed?	
		<input type="radio"/> Yes	<input type="radio"/> No
PGY	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> other
PJT	<input type="radio"/> Internship	<input type="radio"/> Residency	<input type="radio"/> Fellowship
	<input type="radio"/> Research	<input type="radio"/> other	

2. Hospital Name	<input type="text"/>	Date From	<input type="text"/>
Address	<input type="text"/>	Date To	<input type="text"/>
City	<input type="text"/>	State	<input type="text"/>
		Zip Code	<input type="text"/>
Country	<input type="text"/>		
Department/Specialty:	<input type="text"/>	Successfully Completed?	
		<input type="radio"/> Yes	<input type="radio"/> No
PGY	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> other
PJT	<input type="radio"/> Internship	<input type="radio"/> Residency	<input type="radio"/> Fellowship
	<input type="radio"/> Research	<input type="radio"/> other	

3. Hospital Name	<input type="text"/>	Date From	<input type="text"/>
Address	<input type="text"/>	Date To	<input type="text"/>
City	<input type="text"/>	State	<input type="text"/>
		Zip Code	<input type="text"/>
Country	<input type="text"/>		
Department/Specialty:	<input type="text"/>	Successfully Completed?	
		<input type="radio"/> Yes	<input type="radio"/> No
PGY	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> other
PJT	<input type="radio"/> Internship	<input type="radio"/> Residency	<input type="radio"/> Fellowship
	<input type="radio"/> Research	<input type="radio"/> other	

4. Hospital Name
 Address
 City State Zip Code
 Country
 Department/Specialty:

Date From
 Date To

Successfully Completed?
 Yes No

PGY 1 2 3 4 5 other
 PGT Internship Residency Fellowship Research other

5. Hospital Name
 Address
 City State Zip Code
 Country
 Department/Specialty:

Date From
 Date To

Successfully Completed?
 Yes No

PGY 1 2 3 4 5 other
 PGT Internship Residency Fellowship Research other

11. Examination History: List each licensure examination you have taken (USMLE, NBME, NBOME, LMCC, Etc.). If additional space is necessary, copy and attach an additional sheet.

Examination	Date Taken (mm,yyyy)	Pass / Fail	No. of Attempts
USMLE Step 1	<input type="text"/>	<input type="radio"/> Pass <input type="radio"/> Fail	<input type="text"/>
USMLE Step 2 CK	<input type="text"/>	<input type="radio"/> Pass <input type="radio"/> Fail	<input type="text"/>
USMLE Step 2 CS	<input type="text"/>	<input type="radio"/> Pass <input type="radio"/> Fail	<input type="text"/>
USMLE Step 3	<input type="text"/>	<input type="radio"/> Pass <input type="radio"/> Fail	<input type="text"/>
COMLEX Level 1	<input type="text"/>	<input type="radio"/> Pass <input type="radio"/> Fail	<input type="text"/>
COMLEX Level 2 CE	<input type="text"/>	<input type="radio"/> Pass <input type="radio"/> Fail	<input type="text"/>
COMLEX Level 2 PE	<input type="text"/>	<input type="radio"/> Pass <input type="radio"/> Fail	<input type="text"/>
COMLEX Level 3	<input type="text"/>	<input type="radio"/> Pass <input type="radio"/> Fail	<input type="text"/>
NBME Part I	<input type="text"/>	<input type="radio"/> Pass <input type="radio"/> Fail	<input type="text"/>
NBME Part II	<input type="text"/>	<input type="radio"/> Pass <input type="radio"/> Fail	<input type="text"/>
NBME Part III	<input type="text"/>	<input type="radio"/> Pass <input type="radio"/> Fail	<input type="text"/>
NBOME Part I	<input type="text"/>	<input type="radio"/> Pass <input type="radio"/> Fail	<input type="text"/>
NBOME Part II	<input type="text"/>	<input type="radio"/> Pass <input type="radio"/> Fail	<input type="text"/>
NBOME Part III	<input type="text"/>	<input type="radio"/> Pass <input type="radio"/> Fail	<input type="text"/>
LMCC Part I	<input type="text"/>	<input type="radio"/> Pass <input type="radio"/> Fail	<input type="text"/>
LMCC Part II	<input type="text"/>	<input type="radio"/> Pass <input type="radio"/> Fail	<input type="text"/>
FLEX Component 1	<input type="text"/>	<input type="radio"/> Pass <input type="radio"/> Fail	<input type="text"/>
FLEX Component 2	<input type="text"/>	<input type="radio"/> Pass <input type="radio"/> Fail	<input type="text"/>
FLEX Pre-1985	<input type="text"/>	<input type="radio"/> Pass <input type="radio"/> Fail	<input type="text"/>

State Board Exam Date Taken State taken for No. of Attempts Pass / Fail Pass Fail

12. ECFMG and Fifth Pathway

Certificate Number Issue Date

School Name Date From

Address Date To

City State Zip Code Graduation Date

Country Degree

13. State or Professional Licensure: List all state and Canadian provinces where you currently hold or have ever held any type of medical/osteopathic license. You must complete the attached "Licensure Verification" form (Form #1) and forward it to all states in which you have held any healthcare license or certification. The verifying entity must forward all documentation directly to the Board. Some state boards charge a fee for this information. Contact the state board where you hold or held a license to determine their requirements. (Attach additional pages if necessary).

	State / Province	License Type	License Number	License Status	Issue Date
1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Active <input type="radio"/> Inactive	<input type="text"/>
2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Active <input type="radio"/> Inactive	<input type="text"/>
3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Active <input type="radio"/> Inactive	<input type="text"/>
4	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Active <input type="radio"/> Inactive	<input type="text"/>
5	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Active <input type="radio"/> Inactive	<input type="text"/>
6	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Active <input type="radio"/> Inactive	<input type="text"/>
7	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Active <input type="radio"/> Inactive	<input type="text"/>
8	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Active <input type="radio"/> Inactive	<input type="text"/>
9	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Active <input type="radio"/> Inactive	<input type="text"/>
10	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Active <input type="radio"/> Inactive	<input type="text"/>
11	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Active <input type="radio"/> Inactive	<input type="text"/>
12	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Active <input type="radio"/> Inactive	<input type="text"/>
13	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Active <input type="radio"/> Inactive	<input type="text"/>
14	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Active <input type="radio"/> Inactive	<input type="text"/>
15	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Active <input type="radio"/> Inactive	<input type="text"/>

14. Specialty Board Certification: Are you ABMS and / or AOA certified? Yes No

If **Yes** complete information below

Name of Board	<input type="text"/>	Certificate Number	<input type="text"/>	Issue Date	<input type="text"/>
Name of Board	<input type="text"/>	Certificate Number	<input type="text"/>	Issue Date	<input type="text"/>
Name of Board	<input type="text"/>	Certificate Number	<input type="text"/>	Issue Date	<input type="text"/>

15. Chronology of Activities: List ALL activities (medical, non-medical, and postgraduate training) in chronological order beginning with medical school graduation to the PRESENT date, using **MONTH** and **YEAR**. For any non-working time, you **MUST** state on the form exactly what your activities were, such as "vacation" or "seeking employment," as well as your permanent address. If you worked for a physician-staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses. **DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM.** Be sure to indicate the percentage of working time spent in clinical /administrative duties.

Dates: From/To | Activity (medical, non-medical and post graduate training)

FROM: Month Year

Activity/Employer Name (Non-Working*)

Activity Address

City State Zip Code

Position / Department

TO: Month Year

Percent Clinical Percent Administrative

Employment Staff Privileges Administrative Other, Please describe below

In Progress

Dates: From/To | Activity (medical, non-medical and post graduate training)

FROM: Month Year

Activity/Employer Name (Non-Working*)

Activity Address

City State Zip Code

Position / Department

TO: Month Year

Percent Clinical Percent Administrative

Employment Staff Privileges Administrative Other, Please describe below

In Progress

Dates: From/To | Activity (medical, non-medical and post graduate training)

FROM: Month Year

Activity/Employer Name (Non-Working*)

Activity Address

City State Zip Code

Position / Department

TO: Month Year

Percent Clinical Percent Administrative

Employment Staff Privileges Administrative Other, Please describe below

In Progress

Dates: From/To | Activity (medical, non-medical and post graduate training)

FROM: Month Year

Activity/Employer Name (Non-Working*)

Activity Address

City State Zip Code

Position / Department

TO: Month Year

Percent Clinical Percent Administrative

Employment Staff Privileges Administrative Other, Please describe below

In Progress

Dates: From/To | Activity (medical, non-medical and post graduate training)

FROM: Month Year

Activity /Employer Name (Non-Working*)

Activity Address

City State Zip Code

Position / Department

Percent Clinical Percent Administrative

Employment Staff Privileges Administrative Other, Please describe below

In Progress

16. Malpractice: List of all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization. If you do not have any such claims or suits, this section will be blank. Please provide a detailed written description of the background and medical issues involved in each case. Attach additional sheets if necessary.

Name of patient involved: State action took place

Name of Court Case Number (if applicable):

Current status of claim: Open (pending) Closed (settled or judgment) Dismissed (no money paid out)

Amount of judgment or settlement: Amount paid on your behalf

Month and Year of incident Month and Year of lawsuit

Insurance carrier at the time

What is / was your status: Primary Defendant Co-defendant Other

Name of patient involved: State action took place

Name of Court Case Number (if applicable):

Current status of claim: Open (pending) Closed (settled or judgment) Dismissed (no money paid out)

Amount of judgment or settlement: Amount paid on your behalf

Month and Year of incident Month and Year of lawsuit

Insurance carrier at the time

What is / was your status: Primary Defendant Co-defendant Other

Ohio Addendum to Application
ADDITIONAL INFORMATION QUESTIONS

If you answer "YES" to any of the following questions, you are required to furnish complete details, including date, place, reason and disposition of the matter. All affirmative answers must be thoroughly explained on a separate sheet of paper. You must submit copies of all relevant documentation, such as court pleadings, court or agency orders, and institutional correspondence and orders. Please note that some questions require very specific and detailed information. Make sure all responses are complete.

- Yes No 1. Have you ever been denied staff membership at any hospital, nursing home, clinic, health maintenance organization, or similar institution?
- Yes No 2. Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, had privileges suspended or terminated, been put on probation, or been requested to withdraw from or resign privileges at any hospital, nursing home, clinic, health maintenance organization, or other similar institution in which you have trained, been a staff member, or held privileges, for reasons other than failure to maintain records on a timely basis, or failure to attend staff or section meetings?
- Yes No 3. Have you ever resigned from, withdrawn from, or terminated, or have you ever been requested to resign from, withdraw from, or otherwise been terminated from, a position with a medical partnership, professional association, corporation, health maintenance organization, or other medical practice organization, either private or public?
- Yes No 4. Have you ever resigned from, withdrawn from, or have you ever been warned by, censured by, disciplined by, been put on probation by, been requested to withdraw from, dismissed from, been refused renewal of a contract by, or expelled from, a medical school, clinical clerkship, externship, preceptorship, residency, or graduate medical education program?
- Yes No 5. Have you ever transferred from one graduate medical education program to another?
- Yes No 6. Have you ever, for any reason, lost specialty board certification in the U.S. or elsewhere, or been denied such certification, or denied examination for such certification?
- Yes No 7. Has any board, bureau, department, agency or other body, including those in Ohio, in any way limited, restricted, suspended, or revoked any professional license, certificate or registration granted to you; placed you on probation; or imposed a fine, censure or reprimand against you?
- Yes No 8. Have you ever voluntarily surrendered, resigned, or otherwise forfeited any professional license, certificate or registration issued to you by any board, bureau, department, agency, or other body; or have you ever withdrawn any application for licensure, relicensure, or examination, in any state (including Ohio), territory, province, or country?
- Yes No 9. Have you ever, for any reason, been denied licensure or relicensure, application for licensure or relicensure, or the privilege of taking an examination, in any state (including Ohio), territory, province, or country?
- Yes No 10. Have you ever been requested to appear before any board, bureau, department, agency, or other body, including those in Ohio, concerning allegations against you?

- Yes No 11. Have you ever entered into an agreement of any kind, whether oral or written, with respect to a professional license, in lieu of or in order to avoid formal disciplinary action, with any board, bureau, department, agency, or other body, including those in Ohio?
- Yes No 12. Have you ever been notified of any investigation concerning you by any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?
- Yes No 13. Have you ever been notified of any charges, allegations, or complaints filed against you with any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?
- Yes No 14. Have you ever been denied or have you ever surrendered a state or federal controlled substance or drug registration; had it revoked, terminated, or restricted in any way; or been warned, reprimanded, or fined by, or been requested to appear before, the responsible agency?
- Yes No 15. Have you ever pled guilty to, been found guilty of a violation of any law, or been granted intervention or treatment in lieu of conviction regardless of the legal jurisdiction in which the act was committed, other than a minor traffic violation? If yes, submit copies of all relevant documentation, such as police reports, certified court records and any institutional correspondence and orders. Photocopies will not be accepted.
- Yes No 16. Have you ever been arrested, forfeited collateral, bail, or bond for breach or violation of any law, police regulation, or ordinance other than for a minor traffic violation; been summoned into court as a defendant or had any lawsuit filed against you (other than a malpractice suit)? If yes, submit copies of all relevant documentation, such as police reports, certified court records and any institutional correspondence and orders. Photocopies will not be accepted.
- Yes No 17. Have you been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf, or paid such a claim yourself? In addition, ask your malpractice insurance carrier(s) to provide a complete claims history report for the last 10 years to the State Medical Board of Ohio. If your current carrier has provided coverage for less than 10 years, ask your previous carrier to submit a claims history report to the Board.
- Yes No 18. Have you ever been denied professional liability insurance or coverage, or had such insurance or coverage canceled, limited, or restricted in any way?
- Yes No 19. Have you ever been denied or relinquished participation in any third party reimbursement program, whether governmental or private, including Medicaid and Medicare; or had such participation limited, restricted, suspended, or revoked; or been warned, reprimanded, requested to appear before, or fined by the responsible body?
- Yes No 20. Have you ever been denied privileges, or had privileges revoked, suspended, restricted, reduced, or terminated by the Department of Defense, the Veteran's Administration, or any of their respective components?
- Yes No 21. Have you ever been diagnosed as having, or have you been treated for, pedophilia, exhibitionism, or voyeurism?

Yes No 22. a) Within the last ten years, have you been diagnosed with or have you been treated for, bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?

Yes No 22. b) Have you, since attaining the age of eighteen or within the last ten years, whichever period is shorter, been admitted to a hospital or other facility for the treatment of bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?

If you answered YES" to any part of this question, please provide details on a separate sheet, including date of diagnosis or treatment, and a description of your present condition. Include the name, current mailing address, and telephone number of each person who treated you, as well as each facility where you received treatment, and the reason for treatment. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.

For purposes of questions 23 and 24 the following phrases or words have the following meaning:

"Ability to practice medicine" is to be construed to include all of the following:

1. *The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and*
2. *The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and*
3. *The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.*

"Medical condition" includes physiological, mental, or psychological conditions or disorders, such as but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

Yes No 23. Do you have, or have you been diagnosed as having, a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? **You may answer "NO" to this question** if you hold a current training certificate to pursue training in Ohio and the only such medical condition is chemical dependency or substance abuse, and you have successfully completed or are currently receiving treatment at a program approved by this board and have adhered to all statutory requirements as contained in Sections 4731.224 and 4731.25, O.R.C., and related provisions. Any questions concerning approval can be directed to the board offices.

Yes No a) Are the limitations or impairment caused by your medical condition reduced or ameliorated because you receive ongoing treatment or received treatment in the past (with or without medication) or participate in a monitoring program?

If you receive such ongoing treatment or participate in such monitoring program the board will make an individualized assessment of the nature, severity, and duration of the risk associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.

Yes No b) Are the limitation or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?

"Chemical substances" is to be construed to include alcohol, drugs, or medications including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescribers direction, as well as those used illegally.

Yes No 24. Do you use chemical substance(s) which in any way impair or limit your ability to practice medicine with reasonable skill and safety?

Yes No a) Are the limitations or impairment caused by your use of chemical substances reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program?

If you receive such ongoing treatment or participate in such monitoring program the board will make an individualized assessment of the nature, severity, and duration of the risk associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.

- Yes No b) Are the limitation or impairments caused by your use of chemical substances reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?

For purposes of question 25 the following phrases or words have the following meaning:

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or within the past two years.

"Illegal use of controlled substances means the use of controlled substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed healthcare practitioner.

- Yes No 25. Are you currently engaged in the illegal use of controlled substances?

- Yes No a) If "YES," are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not using illegal controlled substances.

This form must be completed if you have responded yes to Additional Information Question #15 and/or #16.
Make additional copies of this form as needed.

Name of applicant

Date of incident

Location of Incident (City / State)

Were you arrested: If the incident was alcohol-related, did you submit to a breath, blood, urine or other test to determine the amount of alcohol in your body?
 Yes No

If Yes, type if test and result

What offense(s) were you charged with?

Were the charges amended?:

Yes No

If Yes, what were the final charges

Disposition:

Pending Charges Dismissed Charges Dropped Conviction

Plea

Other

You must provide a detailed written explanation of the event including a description of the event, what led up to the event and what was learned. This must be described in your own words. Do not reference attached documentation. If additional space is needed, attach a separate sheet. Submit copies of the police report/arrest record, a copy of the charges or ticket, a copy of the final court disposition and any other relevant documentation.

To Mail you application:

You cannot save data typed into this form. Please print 2 copies of your completed form. Keep one copy for your records and mail the other copy to:

State Medical Board of Ohio
30 E. Broad Street, 3rd Floor
Columbus, Ohio 43215

State Medical Board of Ohio

med.ohio.gov

30 E. Broad St., 3rd Floor · Columbus, OH 43215-6127 · (614) 466-3934

Affidavit and Authorization for Release of Information: You must attach a recent (less than 6 months old) passport quality, color photograph of yourself to this form. Take the form to a notary public and sign the form in the presence of the notary public. The notarized form then must be sent directly to this Board.

Affidavit and Authorization For Release of Information

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Application for Physician Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge and exonerate the Board, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the board

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my licensure or permit to practice medicine.

Applicant Photograph

Securely tape or glue in this square a current front-view 2" x 2" passport-type color photo of yourself; photo must have been taken within last six months

Applicant's Signature (must be signed in the presence of a notary)

Applicant's Printed Last Name

Applicant's Printed First Name, Middle Initial and Suffix (e.g., Jr.)

Date of Signature

Notary Public Signature

Date Commission Expires

Subscribed and Sworn to before me on this day of , 20

State Medical Board of Ohio

med.ohio.gov

30 E. Broad St., 3rd Floor · Columbus, OH 43215-6127 · (614) 466-3934

Ohio Addendum to Application EMPLOYER RECOMMENDATION FORM

Dr.

Please print applicants first name and last name

is applying for licensure in the State of Ohio. We would appreciate your assistance in filling out the following evaluation so that we can process their application for licensure. To ensure processing of the physicians application, please complete and return this form to the State Medical Board of Ohio at the above address within two (2) weeks. **The form may also be faxed to the Board at (614) 644-1464.** Your immediate attention to this matter will be greatly appreciated by the applicant as well as by us. Thank you for your time and assistance.

Position(s) held:

Dates of Employment

1. How long have you known the applicant?
2. What is/was your supervisory capacity?
3. At what hospital/ clinic?
4. How would you rate their medical knowledge and techniques?
5. In your opinion is the applicant of good moral and ethical character?
6. Does the applicant work well with peers and medical staff?
7. Does the applicant relate well to patients?
8. How is the applicant's command of the English language (if applicable)?
9. Would you recommend the applicant for licensure?

Additional comments (an additional sheet may be added if needed)

Physician Signature: _____

Name of Physician:

Position:

Telephone number (include area code) Fax number (include area code)

E-mail