



LICENSURE REINSTATEMENT APPLICATION

Employer Recommendation Form

This form is part of an application for license reinstatement. Employer: Send completed forms directly to med.renewal@med.ohio.gov.

THIS SECTION TO BE COMPLETED BY APPLICANT

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

Current Address: _____
Number/Street City State Zip Code

Email: _____ Telephone number: _____

THIS SECTION TO BE COMPLETED BY EMPLOYER

Position(s) held by above-named individual: _____

Name of location where you supervised the applicant: _____

Dates of Employment: _____ to _____
Month/Day/Year Month/Day/Year

How long have you known the applicant? _____

What is/was your supervisory capacity? _____

In your opinion, is the applicant of good moral and ethical character? _____

Would you recommend the applicant for licensure? _____

Please offer the following information in support of the above-named individual's application for licensure reinstatement; circle or highlight your selection:

	Poor		Acceptable				Excellent			
Knowledge and techniques	1	2	3	4	5	6	7	8	9	10
Relationship with patients or clients	1	2	3	4	5	6	7	8	9	10
Ability to work well with peers and staff	1	2	3	4	5	6	7	8	9	10
Command of the English language	1	2	3	4	5	6	7	8	9	10

Additional comments: _____

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. Therefore, I recommend the applicant for a license reinstatement.

Signature _____

Date _____

Name (Please type or print clearly) _____

Title _____

Telephone number _____

Email _____