



TRAINING CERTIFICATE - Medicine or Osteopathic Medicine

Training Program Certification

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)

THIS SECTION TO BE COMPLETED BY OHIO 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 or Program Director

Title

Signature

Date

Phone Number

Email