



State Medical Board of Ohio

30 E. Broad St., 3rd Floor □ Columbus, OH 43215-6127 □ (614) 466-3934 □ Website: <http://med.ohio.gov/>

RENEWAL APPLICATION FOR CERTIFICATE OF CONCEDED EMINENCE MEDICINE OR OSTEOPATHIC MEDICINE

NOTE: Renewal fee is \$1,000.00. Fees submitted are neither refundable nor transferable.

PLEASE TYPE OR PRINT CLEARLY

Identification

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. or 4762., O.R.C. or as otherwise required by state or federal law.

U.S. Social
Security Number:
(if applicable)

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Full Name
(Use no
initials):

Last (Surname)	First	Middle	Suffix (Jr., II)

Maiden Name
or Other
Names
Used (If none,
enter "NONE"):

Last (Surname)	First	Middle	Suffix (Jr., II)

Current
Address:

Number & Street			
City	State	Zip Code	Country

Telephone
Number:

Business:

Area Code & Number

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Home:

Area Code & Number

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Birth
Date:

Mo/Day/Yr

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Birth
Place:

City

State

Country

Email Address:

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RENEWAL FORM 1 – VERIFICATION OF APPOINTMENT

This form must be completed and signed by the Dean of the Medical School where the applicant has been appointed to serve as a faculty member. Indicate the specific staff appointment and dates of appointment. Include a copy of appointment/reappointment letter or contract related to applicant's appointment to serve as a full-time faculty member with the Medical School.

Applicant Name (Last, First, Middle):

Name of Medical School applicant has been appointed as a full-time faculty member:

Appointment Position:

Dates of Appointment:		
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From:

To:

Medical School Address:

City/State/Zip:

Signature of Medical School Dean

Date



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RENEWAL FORM 2 – VERIFICATION OF EMPLOYMENT/QUALIFICATIONS

This form must be completed and signed by a representative of the Academic Medical Center and/or Affiliated Group Practice where the applicant has accepted an employment offer. Indicate the specific employment position and dates of employment. Include a copy of the employment offer and/or contract. **Please provide a letter addressing the bullet points below.**

Name of Academic Medical Center/Affiliated Physician Group Practice:

Employment Position:

Dates of Employment:		
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From:

To:

Academic Medical Center/Affiliated Physician Group Practice Address:

City/State/Zip:

The Academic Medical Center or Affiliated Group Practice **must submit a letter** addressing how the applicant meets the following:

- Applicant's clinical practice is consistent with the established standards in the field in which he/she is practicing.
- Applicant has demonstrated continued scholarly achievement.
- Applicant has demonstrated continued professional achievement consistent with the academic medical center's requirements, established pursuant to standards adopted under Section 3701.351 of the Revised Code, for physicians with staff membership or professional privileges with the academic medical center.



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I hereby certify that the information contained herein is true, accurate and complete to the best of my knowledge, information and belief. I further certify that the applicant is qualified to practice medicine and surgery or osteopathic medicine and surgery and will be permitted to work only within the clinical setting of the academic medical center or for the affiliated physician group practice.

Signature of Academic Medical Center/Affiliated Physician Group Practice Representative

Date

Signature of Academic Medical Center/Affiliated Physician Group Practice Representative

Date



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Certificate of Conceded Eminence Renewal 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. Please note that some questions require very specific and detailed information. Make sure all responses are complete.

QUESTIONS	YES	NO
1) At any time since signing your last application have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?		
2) At any time since signing your last application have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?		
3) At any time since signing your last application have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?		
4) At any time since signing your last application has any board, bureau, department, agency, or any other body, including those in Ohio <u>other than this board</u> , filed any charges, allegations or complaints against you?		
5) At any time since signing your last application have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons <u>other than failure to maintain records on a timely basis or to attend staff meetings?</u>		
6) At any time since signing your last application have you been addicted to or dependent upon alcohol or any chemical substance; relapsed, been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?		

CATEGORY 2

(A MAXIMUM OF 90 CREDITS MAY BE EARNED IN THIS CATEGORY)

Name of Sponsor	Location (City & State)	Description	Date(s)	Credits
Example: Self Instruction		Pediatric Journal	7/1/10 thru 3/30/11	90+

**CERTIFICATE OF CONCEDED EMINENCE
MEDICINE OR OSTEOPATHIC MEDICINE
AFFIDAVIT AND RELEASE OF APPLICANT**

The affidavit and release below **MUST** be completed by **ALL** applicants. The form must be notarized. Failure of any applicant to submit the affidavit completed and notarized with the application will result in your application being considered as incomplete.

ss STATE OF: _____
 COUNTY OF: _____

I, _____, hereby certify under oath that I am the person named in this application for a Certificate of Conceded Eminence in the State of Ohio; that all statements I have made 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 to this Board 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 respect.

I acknowledge that I have read the general information and instructions for all applicants and that I have answered all questions in compliance with these instructions and understand that the fee I submitted is neither refundable nor transferable.

I agree to practice only within the clinical setting of the academic medical center or for the affiliated physician group practice to which I have been appointed.

I further state that by filing this application for a Certificate of Conceded Eminence in the State of Ohio, I hereby authorize and consent to have an investigation made of me. I agree to give any further information which may be required in reference to my past record. I understand that I will not receive a copy of any reports or know their contents and I further understand that the contents of any investigative report will be privileged.

I further understand that my application for a Certificate of Conceded Eminence in the State of Ohio is an ongoing process. I will immediately notify the State Medical Board of Ohio in writing of any changes to the answers to any of the questions contained in the ADDITIONAL INFORMATION section of the application if such a change in an answer is warranted at any time prior to a Certificate of Conceded Eminence being granted to me by the State Medical Board of Ohio. I further understand that failure to complete this application as requested by the Board within six months can be considered abandonment of any request for a Certificate of Conceded Eminence and that any fee I submitted is neither refundable nor transferable.

I authorize and request every person, hospital, clinic, governmental agency (local, state, federal or foreign), court, association, institution, or law enforcement agency having control of any documents, records and other information pertaining to me to furnish to the State Medical Board of Ohio 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 State Medical Board of Ohio or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application, subsequent to the issuance of a Certificate of Conceded Eminence.

I hereby release, discharge, and exonerate the State Medical Board of Ohio, its agents or representatives and any person, hospital, clinic, governmental agency (local, state, federal or foreign), court, association, institution, or law enforcement agency furnishing information, of any and all liability of every nature and kind arising out of investigation made by the State Medical Board of Ohio. I authorize the State Medical Board of Ohio to release information, material, documents, orders or the like relating to me or to this application to any other governmental agency (local, state, federal or foreign); or to any hospital, nursing home, clinic, health maintenance organization or similar institution; or to any professional association.

I further understand that issuance of a Certificate of Conceded Eminence in Ohio will be considered on the truth of the statements and documents contained herein or to be furnished, which if false, can subject me to revocation of said certificate.

Signature of Applicant

Subscribed and sworn to before me this _____ day of _____ 20 _____.

Signature of Notary Public

(NOTARY SEAL)

Date Commission Expires