



State Medical Board of Ohio

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

TRAINING CERTIFICATE RENEWAL

MEDICINE OR OSTEOPATHIC MEDICINE CERTIFICATION OF TRAINING PROGRAM

I am applying for renewal of my training certificate in the State of Ohio. The State Medical Board of Ohio requires that this form be completed by the Ohio training program in which I will be training. Please complete the form and return it directly to the State Medical Board of Ohio at the above address.

THIS SECTION TO BE COMPLETED BY APPLICANT

Name of Applicant: _____
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. **THE DATES ARE NOT TO 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.

Dates of Training
(not to exceed one year): Beginning Date: Ending Date:

I hereby certify that I have checked the credentials of the above applicant, that the statements, as completed, are true to the best of my knowledge and he/she is of good moral character. I further certify that he/she will limit his/her practice and training within the physical confines of the hospital, or facilities for which the training certificate to practice is sought and that he/she will practice only under the supervision of the attending medical staff of such hospital or facility for which the training certificate to practice is granted. I hereby recommend that the above applicant be granted the certificate herein applied for.

HOSPITAL SEAL
(If hospital has no seal, indicate and have form notarized)

Signature of Medical Director or Program Director

Name (please print)

Date

THIS FORM CANNOT BE FAXED