

**OHIO OSTEOPATHIC ASSOCIATION  
APPLICATION FOR CATEGORY 1-C CREDITS  
WHOSE LAST NAME BEGINS WITH THE LETTERS A-B**

**Who should file this form?**

This form should only be completed by osteopathic physicians who are requesting the reclassification and approval of CME activities from Category 2 to Category 1-C. Any D.O. who has obtained forty (40) hours or more of credit approved for osteopathic categories 1-A and 1-B should not file this form.

<u>Mail to:</u>	Ohio Osteopathic Association Committee on Professional Affairs 53 West Third Avenue P.O. Box 8130 Columbus, Ohio 43201-0130	<i>Application fee:</i>	<i>\$25; make check payable to <u>OOA</u>.</i>
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Name:	LAST	FIRST	MIDDLE	SUFFIX (JR., III)
Address:	# & STREET			APT./SUITE #
	CITY	STATE	ZIP CODE	
Telephone Number: (				) (Include area code)

Ohio D.O. License Number:

Hospital Affiliation:

Professional Association Affiliation:

**Section 1 - Request for Category Reclassification**

I hereby request that the following programs, which are not approved for osteopathic CME Category 1-A or 1-B be certified in Category 1-C by the Ohio Osteopathic Association's Committee on Professional Affairs for the purpose of Ohio licensure. (Please attach copy of CME program and other supporting documentation.)

NAME OF ACTIVITY	LOCATION	DATE	EXISTING CLASSIFICATION IN CATEGORY 2	CREDIT HOURS
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**Section 2 - Osteopathic Programs Completed to Date**

I have completed the following osteopathic Category 1 activities specified in "Mandatory Continuing Medical Education Osteopathic," during the current biennium, which may be applied to the forty (40) hour Category 1 minimum.

Name of Activity	Location	Date	Category	Credit Hours
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**Section 3 - Reason(s) for Requesting Reclassification**

The reasons for making this request are: (check all that apply)

- (A) Circumstances require that I attend CME programs near my home and similar osteopathic programs are not available in Ohio or in the geographical area where I practice, that are relevant to my practice.
- (B) I am/was in a non-osteopathic internship, residency or fellowship program which is /was not approved by the American Osteopathic Association. (If checked, please complete Section 4.)
- (C) The courses sponsored by osteopathic organizations are not relevant to my practice in terms of subject matter because (please explain):
- (D) Other reasons for request (please describe as fully as possible):

**Section 4 - Credit for Non-AOA-Approved Training**

If you are seeking CME credit for a non-AOA-approved internship, residency or fellowship program, please complete the following information as fully as possible.

(A) Osteopathic college of graduation:

Date of graduation:

(B) Internship - Name of institution:

City:

State:

Date Started:

Date Completed:

AOA-approved:  Yes  No

AMA-approved:  Yes  No

(C) Residency - Type of residency:

City:

State:

Date Started:

Date Completed:

AOA-approved:  Yes  No

AMA-approved:  Yes  No

(D) Fellowship - Type of Fellowship:

City:

State:

Date Started:

Date Completed:

AOA-approved:  Yes  No

AMA-approved:  Yes  No

(E) Did you ever request AOA-approval for the internship/residency/fellowship program for which you are requesting certification as listed in question number 2?  Yes  No

(F) Please state reasons for entering a non-AOA-approved program:

**AFFIDAVIT\***

ss STATE OF  
COUNTY OF

Before me personally appeared  
who being duly sworn says that he/she is the person referred to in the foregoing request for Category  
1-C Continuing Medical Education credits; that the statements therein are strictly true in every  
respect; and that he/she has read and understands this Affidavit.

(Signature of Affiant)

(SEAL)

Subscribed and sworn to before me this DAY day of MONTH YEAR .

Signature of Official Administering Oath

**\*MUST BE SWORN TO BEFORE A NOTARY OR OTHER  
PERSON AUTHORIZED TO ADMINISTER OATHS**