State Medical Board of Ohio
30 East Broad Street, 3rd Floor
Columbus, OH 43215
med.ohio.gov

PODIATRIC MEDICINE LICENSE APPLICATION

Post Graduate Training Certification

Hospital/Training Institution: Email completed forms directly to license@med.ohio.gov.

THIS SECTION TO BE COMPLETED BY APPLICANT

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

Name of Hospital/Training Institution: _____

Location: _____
Address City State ZIP Code

I hereby authorize the above-named school to furnish the information below to the State Medical Board of Ohio.

_____ _____
Signature of Applicant Date

THIS SECTION TO BE COMPLETED BY HOSPITAL/TRAINING INSTITUTION

Our records indicate that the above named individual participated in our training program from:

_____ to _____
month/day/year *month/day/year*

Type of Program: ◉ Internship ○ Residency ○ Clinical Fellowship

Successfully completed? ◉ Yes ○ No ○ In progress

Accredited by (choose one) ◉ CPME ○ APMA ○ Other _____

What is this section called?

1. Did the applicant ever take a leave of absence or break from his/her training? . . . . . ○
2.
3.
4.
5.

If yes to any of the above, please attach explanation.

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 Title

_____ _____
Signature Date

_____ _____
Phone Number Email