State Medical Board of Ohio

State Medical Board of Ohio
30 East Broad Street, 3rd Floor
Columbus, OH 43215
(614) 466-3934 *med.ohio.gov*

LIMITED PERMIT SUPERVISOR REGISTRATION FORM

INSTRUCTIONS: This registration form must be completed by a respiratory care professional having direct supervision over the limited permit holder whose name appears on this form. Pursuant to Rule 4761-6-01 of the Ohio Administrative Code, each limited permit holder must file a completed supervisor registration form within fifteen (15) days of the beginning date of employment in the practice of respiratory care. A new form must be completed for each new employer or for a change in employment. Send completed form to ***license@med.ohio.gov****.*

THIS SECTION TO BE COMPLETED BY THE LIMITED PERMIT HOLDER

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

Address: _____
Street Address

_____ _____ _____
City State ZIP

THIS SECTION TO BE COMPLETED BY THE SUPERVISOR

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

Position Title: _____

Business Mailing Address: _____
Street Address

_____ _____ _____
City State ZIP

County: _____ License Number: _____

Business Phone Number: _____

I certify the following:

1. The above named permit holder has provided me with a copy of a valid limited permit certificate and a copy of the stamped "Verification of Education" form.

2. All of the information and statements contained within this application are true and correct to the best of my knowledge.

_____
Name (printed)

_____ _____
Signature Date