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

TRAINING CERTIFICATE

Ohio Training Program Change Form

Training program: email completed form to license@med.ohio.gov.

THIS SECTION TO BE COMPLETED BY APPLICANT

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

Ohio Training Certificate Number: _____

THIS SECTION TO BE COMPLETED BY THE NEW TRAINING PROGRAM

Name of Training Program: _____

Training Program Address: _____
Street Address

_____
City State Zip Code

Select only one type of program and enter beginning date:

◯ ACGME/AOA/CPME/APMA accredited internship, residency or clinical fellowship.
Specialty: _____

◯ A non-accredited clinical fellowship program at an institution with ACGME/AOA/CPME/APMA accredited residency program in a clinical field the same as or related to the clinical field of the fellowship program.
Clinical Field of Fellowship: _____
Related ACGME/AOA/CPME/APMA Accredited Residency Program: _____

◯ An elective clinical rotation that lasts not more than one year and is offered to interns, residents, or clinical fellows participating in programs that are located outside this state and meet the requirements of one of the above.
Name of out-of-state accredited program: _____

Beginning Date: _____
Month/Day/Year

I certify that the above information is true and correct to my knowledge.

_____ _____
Name of Medical/Program Director Title

_____ _____
Signature Date

_____ _____
Phone Number Email