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

TRAINING CERTIFICATE

Training Program Change Form

Program: Email completed form directly to certificates@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

Type of Program (check only one):

☐ ACGME/AOA/CPME/APMA accredited internship or residency. Specialty: _____

☐ A 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: _____

CERTIFICATION DATES - Indicate the month, day and year for both the beginning and ending dates in which the training certificate is to be issued. 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.

Beginning Date: _____ Ending Date: _____
Month/Day/Year 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