State Medical Board of Ohio

30 E. Broad St., 3rd Floor
Columbus, Ohio 43215
(614) 466-3934
www.med.ohio.gov

PRACTICE PLAN APPLICATION

**Specific practice plan requirements are outlined in your individual order or agreement. A new practice plan must be submitted anytime there is a change in your employment status and/or practice setting.*

Practitioner Background:

Name: ____

License Type: ___________________________________

Previous Areas of Practice & Board Certification/Training: ____

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Practice Information:

Practice Type: ____

Area of Specialty: ____

Anticipated Duties: ____

Anticipated Work Hours: ____

Practice Hours: ____

Anticipated On Call Duties: ____

Anticipated Average Number of Patients Per Day: _____________________

Practice Address(es): ____

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____

Practice Owner: ____

Number of On Site Staff and Clinical Duties: ____

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____

Chaperone Availability (If Required): ____

Monitoring Physician on Site: _______________________________________

Number of Charts for Review: _______________________________________

Additional Practice Information:

____

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____

____
Printed Name

____________________________ ________________________
Signature Date

____

Contact Information (Email and Phone Number)

Should you have additional questions. Please contact Compliance Officer, Angela Sturgeon, at angela.sturgeon@med.ohio.gov or Compliance Officer, Holly Scott, at holly.scott@med.ohio.gov.