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

LICENSURE REINSTATEMENT APPLICATION

Employer Recommendation Form

This form is part of an application for license reinstatement. Employer: Send completed forms directly to license@med.ohio.gov.

THIS SECTION TO BE COMPLETED BY APPLICANT

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

Current Address: ____
Number/Street City State Zip Code

Email: ______________________ Ohio License No.: ______________________

THIS SECTION TO BE COMPLETED BY EMPLOYER

Position(s) held by above-named individual: ______________________

Name of location where you supervised the applicant: ______________________

Dates of Employment: ______________ to ______________
Month/Day/Year Month/Day/Year

How long have you known the applicant? ______________________

What is/was your supervisory capacity? ______________________

In your opinion, is the applicant of good moral and ethical character? ______________________

Would you recommend the applicant for licensure? ______________________

Please offer the following information in support of the above-named individual's application for licensure reinstatement; circle or highlight your selection:

	Poor			Acceptable				Excellent		
Knowledge and techniques	1	2	3	4	5	6	7	8	9	10
Relationship with patients or clients	1	2	3	4	5	6	7	8	9	10
Ability to work well with peers and staff	1	2	3	4	5	6	7	8	9	10
Command of the English language	1	2	3	4	5	6	7	8	9	10

Additional comments: ____

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. Therefore, I recommend the applicant for a license reinstatement.

______________________ ______________________
Signature Date

______________________ ______________________
Name (Please type or print clearly) Title

______________________ ______________________
Telephone number Email