



PODIATRIC MEDICINE LICENSE APPLICATION

Postgraduate Training Certification

Hospital/Training Institution: Email completed forms directly to license@med.ohio.gov.

THIS SECTION TO BE COMPLETED BY APPLICANT

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

Name of Hospital/Training Institution: _____

Location: _____
Address City State ZIP Code

I hereby authorize the above-named school to furnish the information below to the State Medical Board of Ohio.

Signature of Applicant

Date

THIS SECTION TO BE COMPLETED BY HOSPITAL/TRAINING INSTITUTION

Our records indicate that the above named individual participated in our training program from:

_____ to _____
month/day/year month/day/year

Type of Program: Internship Residency Clinical Fellowship

Successfully completed? Yes No In progress

Accredited by (choose one) CPME APMA Other _____ None

YES NO

1. Did this individual ever take a leave of absence or break from his/her training?
2. Was this individual ever placed on probation?
3. Was this individual ever disciplined or placed under investigation?
4. Were any negative reports for behavioral reasons ever filed by instructors?
5. Were any limitation or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason?

If yes to any of the above, please attach explanation.

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.

Name

Title

Signature

Date

Phone Number

Email