State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127

Richard A. Whitehouse, Esq.
Executive Director

(614) 466-3934
med.ohio.gov

APPLICATION INSTRUCTIONS FOR A PHYSICIAN ASSISTANT CERTIFICATE TO PRACTICE

1. Fill out the enclosed APPLICATION FOR CERTIFICATE TO PRACTICE in its entirety.

2. For verification of your Physician Assistant education as required by Section 4730.11, O.R.C., submit one of the following types of evidence:

   a) An original transcript for your Master's Degree or higher that was obtained from an ARC-PA accredited program. Those documents not in English must be translated; **OR:**

   b) If you do not hold a Master's Degree or higher obtained from an ARC-PA accredited program, submit an original transcript for a degree other than a Master's or higher from an ARC-PA accredited program **and** an original transcript for a Master's or higher degree in a course of study with **clinical relevance** to the practice of Physician Assistant that was obtained from a program accredited by a regional or specialized and professional accrediting agency recognized by the council for higher education accreditation. Those documents not in English must be translated; (these documents may come directly from the college/university or from you) **OR:**

   c) If you do not hold a masters degree or higher as required in (a) and (b) above you must present evidence satisfactory to the Board of your holding a current, valid license or other form of authority to practice as a physician assistant that was issued by another jurisdiction prior to January 1, 2008.

3. You **MUST** have the NCCPA send a verification of certification directly to the Board stating that you have successfully passed their examination, the date of certification and the date of its expiration.

4. If you have changed your name, you **MUST** submit a copy of any and all appropriate legal documents that authorizes each name change. This may be a court decree or a marriage certificate, etc...

5. Complete the Resume form. List all activities in chronological order from date of completion of Physician Assistant training to the present. Do not substitute any other resume for this form. Have your most recent employer submit a letter of verification of employment which includes the period of employment. The Form 1A will not suffice for this letter.

6. Answer all questions under Additional Information. If you answer yes to any of the questions, you are required to furnish complete details, including date, place, reason and disposition of the matters. Please note that some questions require very specific and detailed informtion. Make sure that all responses are complete.

7. The Affidavit and Release of Applicant must be signed and notarized.

8. Attach a recent (taken within the last 6 months) passport size **COLOR** photo to each of the two Form 1's (Certificate of Good Moral Character) **before** forwarding the forms to the two persons who will complete these recommendations. The physician whom you choose to complete Form 1A must be fully licensed in the State in which the form is notarized. The Notary will be notarizing the recommenders signatures, not the applicants.

9. Forward a Form 2 to each state in which you hold or have held licenses/registrations as a Physician Assistant, whether now current or not. If you have never held a license/registrations as a Physician Assistant, disregard this form. Photocopies of the form may be made.

10. Enclose a check or money order for $200.00, made payable to the Richard Cordray, Treasurer of State. FEES SUBMITTED ARE NEITHER REFUNDABLE NOR TRANSFERABLE. Applications submitted without the required fee will not be processed until the fee is received.

11. Ohio Revised Code Section 4730.101 which became effective 3/24/08 requires that all applicants for licensure submit a criminal records check. Enclosed is information that you will need to guide you through this process. Do not send your fingerprints to the Board.

Application processing time is 10-12 weeks. Please be advised that all information submitted will be thoroughly investigated and individuals will be contacted regarding their application as the Board deems necessary.

Once the application is approved by the Board, a certificate to practice will be issued. The Board requires biennial extension of the certificate to practice under Section 4730.14, Ohio Revised Code. Please note that this certificate to practice will need to be renewed every two years in the even years regardless of when the certificate was issued.

CRIMINAL RECORDS CHECK REQUIRED FOR INITIAL LICENSURE PHYSICIAN ASSISTANT (PA)

Chapter 4730 of the Ohio Revised Code requires all individuals applying for an a certificate to practice as a physician assistant with the State Medical Board of Ohio to submit fingerprints for a criminal records check completed by the Ohio Bureau of Criminal Identification and Investigation (BCII) and the Federal Bureau of Investigation (FBI).

Instructions for Individuals Residing in Ohio

Applicants residing in Ohio are required to utilize "National WebCheck," Ohio's electronic fingerprint system, to electronically submit their fingerprints to BCII. The Board will typically receive the results of criminal records check submitted via "National WebCheck" within 7 to 10 business days. In addition to the BCII fee and FBI fee, the electronic fingerprinting company/agency may charge a handling fee to process the fingerprints.

Since the law requires applicants for licensure to submit a criminal records check completed by both BCII and the FBI, applicants MUST use the services of a vendor that participates in the "National WebCheck." The Sheriff's offices in all 88 Ohio counties participate in the "National WebCheck." A list of all vendors, searchable by county, is available online at:

http://www.ohioattorneygeneral.gov/Services/Business/WebCheck

When locating an electronic fingerprinting site on this web page, please note that you MUST use the services of a vendor that has (NWC) listed after the vendor's name. Only these entities participate in "National WebCheck". The Board does not endorse or recommend any specific electronic fingerprinting company/agency.

You need both the BCII and FBI criminal records check for initial licensure. By law, the Board cannot complete the processing of your application until it receives the background check reports from both BCII and FBI.

Steps for "National WebCheck"

- Identify a vendor that participates in the "National WebCheck **(NWC)**."
- Submit your fee directly to the vendor. **DO NOT SEND YOUR FINGERPRINTS OR FEE TO THE BOARD.**
- Request that the criminal records check results from both BCII and FBI be sent directly to:

State Medical Board of Ohio
30 E. Broad St., 3rd Floor
Columbus, Ohio 43215-6127

- Indicate the reason for fingerprinting as: "Required for licensure per ORC 4730.101".
- List the agency code as **1AB002.**

Instructions for Individuals Residing Outside Ohio

Individuals residing outside Ohio must contact the Board by email at med.license@med.state.oh.us to request the appropriate forms. The Board will mail the forms needed for your fingerprints to be processed at your local law enforcement agency.

STATE OF OHIO
APPLICATION FOR PHYSICIAN ASSISTANT CERTIFICATE TO PRACTICE
SECTION 4730.10, REVISED CODE

(PLEASE TYPE OR PRINT CLEARLY)

1. Social Security Number: ______________________________
   Your social security number is required to facilitate reporting to the Healthcare Integrity & Protection Data Bank (42 U.S.C. § 1320a-7e(b), 5 U.S.C. § 552a and 45 C.F.R. pt. 61) and for accurate identification under Ohio child support (§ 2301.373 O.R.C.) It may also be used for investigation/enforement purposes.

2. Full Name (Use no initials): ______________________________
   LAST FIRST MIDDLE SUFFIX (Jr, II)

3. Maiden Name or Other Names Used (If none, enter "NONE"): ______________________________
   LAST FIRST MIDDLE SUFFIX (Jr, II)
   ____
   LAST FIRST MIDDLE SUFFIX (Jr, II)

If you have both a home and business address, please designate which is your mailing address.

4. Current Home Address: (required)
   ❑ mailing address
   ____
   NUMBER & STREET APT
   ____
   CITY STATE ZIP CODE COUNTY

5. Current Business Address: (if applicable)
   ❑ Mailing address
   ____
   NUMBER & STREET APT
   ____
   CITY STATE ZIP CODE COUNTY

6. Telephone Number: Home: ______________ Business: ______________

7. Date of Birth: ____/____/____ Place of Birth: ______________________________
   MO/DAY/YR CITY STATE COUNTRY

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8. Were you ever a member of the Armed Forces? ☐ Yes ☐ No
If yes, indicate:

Branch: ______________________________ Military Service Number: ____________________

Dates of Active Duty: _____/_____/_____ to _____/_____/_____

9. List all Physician Assistant school(s) which you have attended and SUBMIT COPY OF CERTIFICATE(S):

NAME OF INSTITUTION	CITY/STATE	DATE OF GRADUATION	DEGREE RECEIVED (if any)

10. List **ALL** of the National Commission on Certification of Physician's Assistant Examinations you have taken. YOU MUST SUBMIT A COPY OF YOUR VALID NCCPA CERTIFICATE OR WALLET CARD:

Date Taken: ______/______ ☐ Pass ☐ Fail
Date Taken: ______/______ ☐ Pass ☐ Fail
Date Taken: ______/______ ☐ Pass ☐ Fail
Date Taken: ______/______ ☐ Pass ☐ Fail

11. What is your NCCPA certificate number?____________________________________.

12. What is the expiration date of your NCCPA certificate? _________________________.

13. Have you ever been registered/licensed/certified as a Physician Assistant in any state (including Ohio) ?
☐ Yes ☐ No If yes, indicate state, registration number, date issued and whether or not registration is current: You must have each license verified from each state regardless of whether or not this license is current.

State:_______ Number:_________ Date Issued: ____/____ Current? ☐ Yes ☐ No
State:_______ Number:_________ Date Issued: ____/____ Current? ☐ Yes ☐ No
State:_______ Number:_________ Date Issued: ____/____ Current? ☐ Yes ☐ No
State:_______ Number:_________ Date Issued: ____/____ Current? ☐ Yes ☐ No

14. Have you requested that your criminal background check be sent to the State Medical Board Of Ohio? ☐ Yes ☐No

CONTINUED ⇨

PHYSICIAN ASSISTANT RESUME

List ALL activities in chronological order from the date of COMPLETION OF PHYSICIAN ASSISTANT TRAINING to the PRESENT time, using month and year. For any non-working time, you MUST state on the resume exactly what your activities were, such as "vacation" or "seeking employment", as well as your permanent address for this period. Failure to include complete addresses, including zip codes, will result in delay in processing your application. DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM. If you require more space, attach separate sheets. Have your most recent employer submit a letter of verification of employment which includes the period of employment.

LIST ALL DATES IN CHRONOLOGICAL ORDER

Dates	Employer or Non-Working Activity / Full Address	Position
Month / Year Month / Year	Employer or Non-Working Activity: Full Address:	Position
Month / Year Month / Year	Employer or Non-Working Activity: Full Address:	Position
Month / Year Month / Year	Employer or Non-Working Activity: Full Address:	Position
Month / Year Month / Year	Employer or Non-Working Activity: Full Address:	Position
Month / Year Month / Year	Employer or Non-Working Activity: Full Address:	Position

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PHYSICIAN ASSISANT RESUME

Dates	Employer / Address	Position
Month / Year Month / Year	Employer or Non-Working Activity: Full Address:	Position
Month / Year Month / Year	Employer or Non-Working Activity: Full Address:	Position
Month / Year Month / Year	Employer or Non-Working Activity: Full Address:	Position
Month / Year Month / Year	Employer or Non-Working Activity: Full Address:	Position
Month / Year Month / Year	Employer or Non-Working Activity: Full Address:	Position
Month / Year Month / Year	Employer or Non-Working Activity: Full Address:	Position

CONTINUED ⇨

PHYSICIAN ASSISTANT
CERTIFICATE TO PRACTICE
ADDITIONAL INFORMATION

If you answer "YES" to any of the following questions, you are required to furnish complete details, including date, place, reason and disposition of the matter. All affirmative answers must be thoroughly explained on a separate sheet of paper. Please note that some questions require very specific and detailed information. Make sure all responses are complete.

(Please place a ☑ in the yes or no box)

		YES	NO
1.	Have you ever been terminated, been put on probation by, requested to resign from, withdraw, or otherwise terminate your position with a medical partnership, professional association, corporation, health maintenance organization, or other medical practice organization, either private or public?	❑	❑
2.	Has any board, bureau, department, agency or other body, including those in Ohio, put you on probation, in any way limited, restricted, suspended, or revoked any professional license, certificate or registration granted to you, or imposed a fine or reprimand against you?	❑	❑
3.	Have you ever voluntarily surrendered any professional license, certificate, or registration issued to you by any board, bureau, department, agency, or other body, including those in Ohio?	❑	❑
4.	Have you ever been requested to appear before any board, bureau, department, agency, or other body, including those in Ohio, concerning allegations against you?	❑	❑
5.	Have you ever entered into an agreement of any kind, whether oral or written, with respect to a professional license, certificate or registration, in lieu of formal disciplinary action, with any board, bureau, department, agency, or other body, including those in Ohio?	❑	❑
6.	Have you ever been notified of any investigation concerning you by any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license, certificate or registration?	❑	❑
7.	Have you ever been notified of any charges, allegations, or complaints filed against you with, any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license, certificate or registration?	❑	❑

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		YES	NO
8.	Have you ever been denied licensure, certification or registration, application for licensure, certification or registration, or privilege of taking examination, or have you ever withdrawn any application in any state (including Ohio), territory, province or country for any reason?	❑	❑
9.	Have you ever been convicted or found guilty of a violation of any law, regardless of the legal jurisdiction in which the act was committed, other than a minor traffic violation?	❑	❑
10.	Have you ever forfeited collateral, bail, or bond for breach or violation of any law, police regulation, or ordinance other than for a minor traffic violation; been summoned into court as a defendant or had any lawsuit (other than a malpractice suit) filed against you?	❑	❑
11.	Have you been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf, or paid such a claim yourself? If yes, include the case name, case number, court and address, date filed, and a summary of the underlying events. Indicate current status, including amount of settlement or judgment, if any. In addition, ask your malpractice insurance carrier(s) to provide a complete claims history report for the last 10 years to the State Medical Board of Ohio. If your current carrier has provided coverage for less than 10 years, ask your previous carrier to submit a claims history report to the Board.	❑	❑
12.	Have you ever been denied or relinquished participation in any third party reimbursement program, whether governmental or private, or had such participation limited, restricted, suspended, or revoked; put on probation, or been warned, reprimanded, requested to appear before, or fined by the responsible body?	❑	❑
13.	Have you ever been denied privileges, put on probation by, or had privileges revoked, suspended, restricted, reduced or terminated by the Department of Defense or the Veteran's Administration?	❑	❑
14.	Have you ever been diagnosed as having, or have you been treated for, pedophilia, exhibitionism, or voyeurism? If yes, please explain	❑	❑
15	a)Within the last ten years, have you been diagnosed with or have you been treated for, bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?	❑	❑
	b) Have you, since attaining the age of eighteen or within the last ten years, whichever period is shorter, been admitted to a hospital or other facility for the treatment of bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?	❑	❑

If you answered "YES" to any part of this question, please provide details on a separate sheet, including date(s) of diagnosis or treatment, and a description of your present condition. Include the name, current mailing address, and telephone number of each person who treated you, as well as each facility where you received treatment, and the reason for treatment.

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For purposes of questions 16 and 17 the following phrases or words have the following meaning:

"Ability to practice as a physician assistant" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and

2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental, or psychological conditions or disorders, such as but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

		YES	NO
16.	Do you have, or have you been diagnosed as having, a medical condition which in any way impairs or limits your ability to practice as a physician assistant with reasonable skill and safety? If yes, please explain.	❑	❑
a)	Are the limitations or impairment caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program? If yes, please explain. If you receive such ongoing treatment or participate in such monitoring program the board will make an individualized assessment of the nature, severity, and duration of the risk associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.	❑	❑
b)	Are the limitation or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? If yes, please explain.	❑	❑

OVER ⇨

"Chemical substances" is to be construed to include alcohol, drugs, or medications including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescribers direction, as well as those used illegally.

	YES	NO
17. Do you use chemical substance(s) which in any way impair or limit your ability to practice as a physician assistant with reasonable skill and safety? If yes, please explain.	❑	❑
a) Are the limitations or impairment caused by your use of chemical substances reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program? If yes, please explain.	❑	❑
If you receive such ongoing treatment or participate in such monitoring program the board will make an individualized assessment of the nature, severity, and duration of the risk associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.		
b) Are the limitation or impairments caused by your use of chemical substances reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? if yes, please explain.	❑	❑

* *

For purposes of question 18 the following phrases or words have the following meaning:

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or within the past two years.

"Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed healthcare practitioner.

	YES	NO
18. Are you currently engaged in the illegal use of controlled substances?	❑	❑
a) If "YES," are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not using illegal controlled substances. If yes, please explain.	❑	❑

AFFIDAVIT AND RELEASE OF APPLICANT

The affidavit and release below must be completed by ALL applicants. The form must be notarized.

STATE OF ________________________________

COUNTY OF ______________________________

I, ____________________________________, hereby certify under oath that I am the person named in this application for a Physician Assistant certificate to practice in the State of Ohio; that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished to this Board with respect to my application; and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every respect.

I acknowledge that I have read the instructions for all applicants and I have answered all questions in compliance with these instructions. I understand that the fee I submitted is not refundable or transferable.

I further state that by filing this application for a Physician Assistant certificate to practice in the State of Ohio, I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness for registration as a Physician Assistant. I agree to give any further information which may be required in reference to my past record. I understand that I will not receive a copy of any reports or know their contents and I further understand that the contents of any investigative report will be privileged.

I further understand that failure to complete this application as requested by the Board within six months can be considered as abandonment of any request for a certificate to practice and that any fee I submitted is not refundable or transferable.

I authorize and request every person, hospital, clinic, governmental agency (local, state, federal or foreign), court, association, institution, or law enforcement agency having control of any documents, records and other information pertaining to me to furnish to the State Medical Board of Ohio any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the State Medical Board of Ohio or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application, subsequent licensure or practice thereunder.

I hereby release, discharge, and exonerate the State Medical Board of Ohio, it agents or representatives, and any person furnishing information, from any and all liability of every nature and kind arising out of investigation made by the State Medical Board of Ohio. I authorize the State Medical Board of Ohio to release information, material, documents, orders or the like relating to me or to this application to any other governmental agency (local, state, federal or foreign); or to any hospital, nursing home, clinic, health maintenance organization, or similar institution, or to any professional association.

I further understand that consideration of this application is based on the truth of the statements and documents made or furnished in connection with it. If any of the statements are false, I may be permanently denied licensure as a Physician Assistant in Ohio.

____
Signature of Applicant

Sworn to and subscribed before me this __________ day of ____________________________, 20 ________.

____
Notary Public Signature

(NOTARY SEAL)

____
Date Commission Expires

PHYSICIAN ASSISTANT CERTIFICATE TO PRACTICE

FORM 1A - CERTIFICATE OF GOOD MORAL CHARACTER

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physician must be sufficiently acquainted with the applicant for at least SIX months. Relatives may not serve as recommending physicians. This form must be notarized. The notary is notarizing the recommender's signature. All questions must be answered.

DO NOT COMPLETE UNLESS A COLOR PHOTOGRAPH OF THE APPLICANT IS ATTACHED, THE APPLICANT HAS SIGNED AND INDICATED THE DATE THE PHOTOGRAPH WAS TAKEN. BLACK & WHITE PHOTOS ARE NOT ACCEPTABLE

I, ______________________________________, a licensed and practicing physician in the state of ______________,
(Recommending Physician) (State of Residence)

affirm that _____________________________________ has been known to me personally and/or professionally for
(Name of Applicant)

________ years and that he/she is of good moral and ethical character. Further, the photograph affixed hereto is a

genuine likeness of the applicant. I hereby recommend him/her for a certificate to practice as a physician assistant in Ohio.

____
Signature of Recommending Physician

____
Address of Recommending Physician

____
Name of Recommending Physician (print or type legibly)

____
City State Zip

____
State of Licensure and License Number

____
(Area Code) Telephone Number

Subscribed and sworn to before me this _______ day of ______________________, 20 ______

NOTARY SEAL

PHOTOGRAPH

Staple a recent passport size **COLOR** photo of applicant here; must have been taken within the last six months *(black & white photos* ***are not*** *acceptable)*

____
Signature of Notary Public

____
Date Commission Expires

____
Signature of Applicant

Date Photo Taken: _____/_____
Mo/Yr

RETURN TO: STATE MEDICAL BOARD OF OHIO
30 E. BROAD ST., 3RD FLOOR
COLUMBUS, OH 43215-6127

PHYSICIAN ASSISTANT CERTIFICATE TO PRACTICE

FORM 1B - CERTIFICATE OF GOOD MORAL CHARACTER

This form is to be completed by an adult, who has been sufficiently acquainted with the applicant for at least SIX months. Relatives may not serve as recommenders. This form must be notarized. The notary is notarizing the recommender's signature. All questions must be answered.

DO NOT COMPLETE UNLESS A COLOR PHOTOGRAPH OF THE APPLICANT IS ATTACHED, THE APPLICANT HAS SIGNED AND INDICATED THE DATE THE PHOTOGRAPH WAS TAKEN. BLACK & WHITE PHOTOS ARE NOT ACCEPTABLE

I, ____________________________________, affirm that ______________________________________ has been
(Name of Recommender) (Name of Applicant)

known to me personally and/or professionally for __________ years and that he/she is of good moral and ethical character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I hereby recommend him/her for a certificate to practice as a physician assistant in Ohio.

____
Signature of Recommender

____
Name of Recommender (print or type legibly)

____
Address of Recommender

____
City State Zip

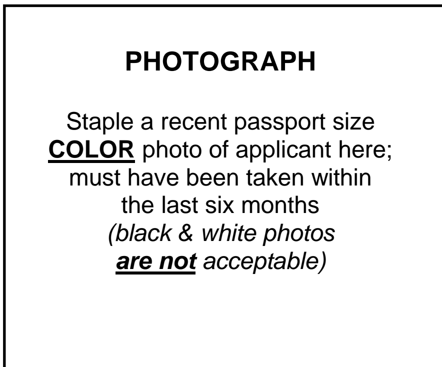
____
(Area Code) Telephone Number

Subscribed and sworn to before me this _______ day of _____________________, 20 ______

NOTARY SEAL

____
Signature of Notary Public

____
Date Commission Expires



PHOTOGRAPH

Staple a recent passport size **COLOR** photo of applicant here; must have been taken within the last six months *(black & white photos **are not** acceptable)*

____
Signature of Applicant

Date Photo Taken: _____/_____
Mo/Yr

RETURN TO: STATE MEDICAL BOARD OF OHIO
30 E. BROAD ST., 3RD FLOOR
COLUMBUS, OH 43215-6127

PHYSICIAN ASSISTANT CERTIFICATE TO PRACTICE

FORM 2 - VERIFICATION OF LICENSE/REGISTRATION

I am applying for a physician assistant certificate to practice in the State of Ohio. The State Medical Board of Ohio requires that this form be completed by each state in which I HOLD OR HAVE HELD licenses/registrations/certifications, whether now current or not. ***Please complete the form and return it to the State Medical Board of Ohio***. Thank you.

TO BE COMPLETED BY APPLICANT

______________________________ Name (last) (first) (middle) (suffix)

______________________________ License # Issue Date

______________________________ Street Address Apt.

______________________________ Date of Birth (month/day/year)

______________________________ City State Zip Code

______________________________ P. A. Program

I hereby authorize the licensing agency of the state of__________________________ to furnish the information below to the State Medical Board of Ohio.

______________________________ Signature of Applicant

______________________ Date

TO BE COMPLETED BY STATE BOARD

Name of Licensee: ______________________________ State______________________

License/Registration #: ______________________________ Date Issued: ____/____/____

Is the license/registration current? ❑ YES ❑ NO If not, please explain: _______________

Type of license/registration:____

OVER ⇨

Revised 2/16/06

1. Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state?
   ❑ YES ❑ NO ❑ Cannot Answer under current state law
   If yes, please attach details. Include information as to whether licensee is aware of investigation.

2. Have formal disciplinary proceedings been initiated against applicant or applicant's license/registration by a disciplinary authority in your state?
   ❑ YES ❑ NO ❑ Cannot Answer under current state law
   If yes, please attach details.

3. Has the applicant ever been warned, censured or in any other manner disciplined or has applicant's license/registration been revoked, suspended, or in any other manner limited by a licensing or disciplinary authority in your state?
   ❑ YES ❑ NO ❑ Cannot Answer under current state law
   If yes, please attach details.

(BOARD SEAL)

____
Signature

____
Title

____
Date

RETURN TO: STATE MEDICAL BOARD OF OHIO
30 E. BROAD ST., 3RD FLOOR
COLUMBUS, OH 43215-6127