



LICENSURE APPLICATION

License Verification

Applicant: Most states submit electronic verification of a license upon your request. However, if your state is unable to provide you with electronic documentation, feel free to use this form to submit your request to the licensing authority of that state. Licensing Authority: Send completed forms to license@med.ohio.gov.

THIS SECTION TO BE COMPLETED BY APPLICANT

Full Name: Last First Middle Suffix (Jr., II)
License Number: Date of Birth: Month/Day/Year
I hereby authorize the licensing agency for the state/province of
to furnish the information below to the State Medical Board of Ohio.
Signature of Applicant Date

THIS SECTION TO BE COMPLETED BY STATE BOARD OR CANADIAN PROVINCE

Name of Licensee: Last First Middle Suffix (Jr., II)
State/Province: License Number:
Original Issue Date: Month/Day/Year Expiration Date: Month/Day/Year
License Type: full/unrestricted temporary training certificate
educational limited permit other:

If you answer YES to any of the following questions, please attach detailed documentation.

Is the applicant currently the subject of a pending investigation by licensing or disciplinary authority in your state?

- Yes No Cannot answer under current state law

Have formal disciplinary proceedings been initiated against the applicant's license by a disciplinary authority in your state?

- Yes No Cannot answer under current state law

Has the applicant ever been warned, censured, or in any other manner disciplined, or has the applicant's license been revoked, or in any other manner limited by a licensing or disciplinary authority in your state?

- Yes No Cannot answer under current state law

I certify that the above information is an accurate account of the above-named individual's official records maintained and is true and correct to my knowledge.

Name (printed) Title
Signature Date