State Medical Board of Ohio

30 E. Broad St., 3rd Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: http://med.ohio.gov/

RE: Visiting Medical Faculty Certificate

Dear Doctor:

Attached is an application and instructions for a Visiting Medical Faculty Certificate. PLEASE READ THE INSTRUCTIONS THOROUGHLY BEFORE COMPLETING THE APPLICATION. You must complete the entire application and submit all required documentation.

Please note that once submitted an application cannot be withdrawn without the approval of the Board. Fees submitted are neither refundable nor transferable, even if a withdrawal is permitted.

Ohio law does not provide for temporary or provisional licensure while your application for a visiting medical faculty certificate is being processed. **Practice prior to issuance of a Visiting Medical Faculty Certificate constitutes the illegal practice of medicine.**

The application processing time for a Visiting Medical Faculty Certificate is ordinarily 2 to 4 weeks after receipt of an application by the Board. An incomplete application or any unusual circumstances may require additional processing time.

ELIGIBILITY FOR A VISITING MEDICAL FACULTY CERTIFICATE

To be eligible for a Visiting Medical Faculty Certificate pursuant to Section 4731.293, Ohio Revised Code and Rule 4731-6-32, Ohio Administrative Code you must:

- Hold a current unrestricted license or right to practice medicine and surgery or osteopathic medicine and surgery issued by another state or country.

- Been appointed to serve in this state on the academic staff of a medical school accredited by the Liaison Committee on Medical Education or an osteopathic medical school accredited by the American Osteopathic Association.

The holder of a Visiting Medical Faculty Certificate may practice medicine and surgery or osteopathic medicine and surgery only as is incidental to the teaching duties at the school or the teaching hospitals affiliated with the school.

A Visiting Medical Faculty Certificate is valid for the shorter of three (3) years or the duration of the holder's appointment to the academic staff of the school. The Certificate may not be renewed and only one visiting medical faculty certificate may be granted.

VISITING MEDICAL FACULTY CERTIFICATE
MEDICINE OR OSTEOPATHIC MEDICINE

APPLICATION INSTRUCTIONS

Review the following instructions and the entire application packet carefully before completing the application. Processing will not begin until the appropriate fee is received. Failure to submit all required information and documentation will result in processing delays.

1. Complete the enclosed **APPLICATION FOR A VISITING MEDICAL FACULTY CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE** in its entirety. You must provide a response to each section or question of the application as instructed. Mark "N/A" if Not Applicable.

2. Attach a recent (taken within the last six months) passport-type size **COLOR** photograph of yourself to the Physical Description section in the application. Black and white photographs will not be accepted.

3. Submit a check or money order in the amount of **$375.00** made payable to **Kevin L. Boyce, State Treasurer** with your application. **FEES ARE NEITHER REFUNDABLE NOR TRANSFERABLE**.

4. Enclose a photocopy of your medical school diploma. If your diploma is not in English or is in Latin, you must also enclose an official certified translation. The translator must attest to the translation and sign and date the translation in the presence of a notary or officer authorized to administer oaths. The translation must be made by one of the following individuals or institutions:

    a) A professor of languages in the language of your diploma, the translation must bear the letterhead of the institution at which he/she is a professor; or
    b) Your medical school of graduation. The translation must bear the letterhead of the institution (certificates of graduation are not acceptable); or
    c) A recognized translation service in the United States (e.g., Berlitz). The translation service must be in the business of performing such translations and properly registered in the state of operation, if so required; or
    d) A foreign embassy or consulate authorized to perform translations. The translation must be performed by an employee of the embassy or consulate. Translations performed by a non-employee or an embassy or consulate where the translator's signature is merely certified by the embassy are NOT acceptable; or
    e) A priest or cleric only in the case of Latin documents.

    Translations by friends, relatives or yourself are not acceptable.

5. If you have changed your name you must submit a photocopy of the appropriate legal document which authorizes the name change (i.e., marriage certificate, divorce decree). Any document in a foreign language must be accompanied by an official, certified translation as provided in instruction #4 above.

6. Enclose a copy of a current, unrestricted license or other document certifying the right to practice medicine or osteopathic medicine or surgery issued by another state or country (i.e., certificate, wallet card) showing expiration date. Any document in a foreign language must be accompanied by an official, certified translation as provided in instruction #4 above.

7. Forward the enclosed Verification of Activity (Form 1) form to the institution where you will be on the medical faculty for completion. In addition, you must submit a copy of your contract.

Additional Information Section

Please keep a copy of the Additional Information questions for your own reference. If any answers to these questions change while your application is pending, you must notify the State Medical Board of Ohio in writing.

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APPLICATION FOR VISITING MEDICAL FACULTY CERTIFICATE MEDICINE OR OSTEOPATHIC MEDICINE

NOTE: Application fee is $375.00. Fees submitted are neither refundable nor transferable.

PLEASE TYPE OR PRINT CLEARLY

Identification

Your social security number is required to facilitate reporting to the federal 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 the federal and state child support enforcement law (42 U.S.C. §666 and §3123.50, O.R.C.). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. §11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with Chapters 4730., 4731., 4760. or 4762., O.R.C. or as otherwise required by state or federal law.

U.S. Social Security Number:

Full Name **(Use no initials**): Last (Surname) | First | Middle | Suffix (Jr., II)

Maiden Name or Other Names Used **(If none, enter "NONE")**: Last (Surname) | First | Middle | Suffix (Jr., II)

Current Address: Number & Street

City | State | Zip Code | Country

Telephone Number: Business: Area Code & Number ( ) Home: Area Code & Number ( )

Birth Date: Mo/Day/Yr / /

Birth Place: City | State | Country

Immigration or citizenship status: Indicate which of the following document(s) you currently possess:

- ❑ U.S. Birth Certificate
- ❑ Certificate of Naturalization
- ❑ Declaration of Intention (issued by the U.S. District Court)
- ❑ Alien Registration Receipt card (issued by the Department of Immigration & Naturalization)
- ❑ Approved Petition for an Immigrant Visa (issued by the Department of Immigration)
- ❑ Other (please specify):_____

Do you have a valid ECFMG Certificate? ❑ Yes ❑ No

Number: | Date Issued: Mo/Day/Yr / /

Medical or Osteopathic Education

Medical or Osteopathic School of Graduation:

School Name

City | State | Country

Dates Attended: From: Mo/Yr / To: Mo/Yr /

Degree Received: | Date Received Mo/Day/Yr / /

Fifth Pathway Program

Fifth Pathway Program **(if none, enter "NONE")**:

Hospital or Institution

Name of Medical School

City | State | Country

Dates Attended: From: Mo/Yr / To: Mo/Yr /

Qualifying exam taken: | Date Taken: Mo/Yr /

Applicant Name:_____ Date:_____

License in the United States or Other Country

List the state or country in which you hold a current, unrestricted license or right to practice medicine or osteopathic medicine and surgery. Indicate the initial date of issuance of that right or practice and the expiration date, if any.

State/Country	Issue Date	License #	License Current
	Mo/Yr /		❑ YES ❑ NO Expire(d):_____

Physical Description

Staple a recent (taken within the last six months) passport-type **COLOR** photograph of applicant in the space provided. Black and white photographs will not be accepted.

STAPLE
COLOR
PHOTOGRAPH
HERE

Photograph must have been taken within last six months (Black and white photos cannot be accepted)

PHYSICAL DESCRIPTION

Height _____
Weight _____
Hair Color _____
Eye Color _____
Identifying Marks _____
_____

Date Photo Taken:_____/_____
mo/yr

Applicant Name:_____ Date:_____

VISITING MEDICAL FACULTY CERTIFICATE
MEDICINE OR OSTEOPATHIC MEDICINE
DESCRIPTION OF ACTIVITY

I, hereby certify that I will be performing the following duties with respect to the Visiting Medical Faculty Certificate:

Location

Name of Medical/Osteopathic School:
Street Address
City State

Dates: From: Mo/Day/Yr / / To: Mo/Day/Yr / /

Description of Duties:

VISITING MEDICAL FACULTY CERTIFICATE
MEDICINE OR OSTEOPATHIC MEDICINE
RESUME OF ACTIVITIES

List ALL activities in chronological order from the completion of graduate medical education 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.* If in private practice, indicate the hospitals where you hold or have held privileges and include complete dates and addresses. For any time in which you worked for an "emergency medical group" or did "locum tenens", you must list all hospitals where you worked and include complete dates and addresses. **DO NOT SUBSTITUTE ANY OTHER RESUME OR CV FOR THIS FORM**. Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space, please attach separate sheets.

From Month/Year ____/____ To Month/Year ____/____	Hospital, University, Other or non-working activity ________________ Complete Street Address ________________ Number & Street ________________ City State/Country Zip Code	Position & Department	%Clinical ________ %Admin.
From Month/Year ____/____ To Month/Year ____/____	Hospital, University, Other or non-working activity ________________ Complete Street Address ________________ Number & Street ________________ City State/Country Zip Code	Position & Department	%Clinical ________ %Admin.
From Month/Year ____/____ To Month/Year ____/____	Hospital, University, Other or non-working activity ________________ Complete Street Address ________________ Number & Street ________________ City State/Country Zip Code	Position & Department	%Clinical ________ %Admin.
From Month/Year ____/____ To Month/Year ____/____	Hospital, University, Other or non-working activity ________________ Complete Street Address ________________ Number & Street ________________ City State/Country Zip Code	Position & Department	%Clinical ________ %Admin.
From Month/Year ____/____ To Month/Year ____/____	Hospital, University, Other or non-working activity ________________ Complete Street Address ________________ Number & Street ________________ City State/Country Zip Code	Position & Department	%Clinical ________ %Admin.

Applicant Name:______________________________ Date:____________________

From Month/Year ___/___ To Month/Year ___/___	Hospital, University, Other or non-working activity ____ Complete Street Address ____ Number & Street ____ City State/Country Zip Code	Position & Department	%Clinical ____ %Admin.
From Month/Year ___/___ To Month/Year ___/___	Hospital, University, Other or non-working activity ____ Complete Street Address ____ Number & Street ____ City State/Country Zip Code	Position & Department	%Clinical ____ %Admin.
From Month/Year ___/___ To Month/Year ___/___	Hospital, University, Other or non-working activity ____ Complete Street Address ____ Number & Street ____ City State/Country Zip Code	Position & Department	%Clinical ____ %Admin.
From Month/Year ___/___ To Month/Year ___/___	Hospital, University, Other or non-working activity ____ Complete Street Address ____ Number & Street ____ City State/Country Zip Code	Position & Department	%Clinical ____ %Admin.
From Month/Year ___/___ To Month/Year ___/___	Hospital, University, Other or non-working activity ____ Complete Street Address ____ Number & Street ____ City State/Country Zip Code	Position & Department	%Clinical ____ %Admin.
From Month/Year ___/___ To Month/Year ___/___	Hospital, University, Other or non-working activity ____ Complete Street Address ____ Number & Street ____ City State/Country Zip Code	Position & Department	%Clinical ____ %Admin.

Applicant Name:________________________________ Date:____________________

VISITING MEDICAL FACULTY CERTIFICATE
MEDICINE OR OSTEOPATHIC MEDICINE
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 denied staff membership at any hospital, nursing home, clinic, health maintenance organization, or similar institution?	❑	❑
2.	Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, had privileges suspended or terminated, been put on probation, or been requested to withdraw from or resign privileges at any hospital, nursing home, clinic, health maintenance organization, or other similar institution in which you have trained, been a staff member, or held privileges, for reasons other than failure to maintain records on a timely basis, or failure to attend staff or section meetings?	❑	❑
3.	Have you ever resigned from, withdrawn from, or terminated, or have you ever been requested to resign from, withdraw from, or otherwise been terminated from, a position with a medical partnership, professional association, corporation, health maintenance organization, or other medical practice organization, either private or public?	❑	❑
4.	Have you ever resigned from, withdrawn from, or have you ever been warned by, censured by, disciplined by, been put on probation by, been requested to withdraw from, dismissed from, been refused renewal of a contract by, or expelled from, a medical school, clinical clerkship, externship, preceptorship, residency, or graduate medical education program?	❑	❑
5.	Have you ever transferred from one graduate medical education program to another?	❑	❑
6.	Have you ever, for any reason, lost specialty board certification in the U.S. or elsewhere, or been denied such certification, or denied examination for such certification?	❑	❑
7.	Has any board, bureau, department, agency or other body, including those in Ohio, in any way limited, restricted, suspended, or revoked any professional license, certificate or registration granted to you; placed you on probation; or imposed a fine, censure or reprimand against you?	❑	❑
8.	Have you ever voluntarily surrendered, resigned, or otherwise forfeited any professional license, certificate or registration issued to you by any board, bureau, department, agency, or other body; or have you ever withdrawn any application for licensure, relicensure, or examination, in any state (including Ohio), territory, province, or country?	❑	❑
9.	Have you ever, for any reason, been denied licensure or relicensure, application for licensure or relicensure, or the privilege of taking an examination, in any state (including Ohio), territory, province, or country?	❑	❑

Applicant Name:_____ Date:_____

		YES	NO
10.	Have you ever been requested to appear before any board, bureau, department, agency, or other body, including those in Ohio, concerning allegations against you?	❑	❑
11.	Have you ever entered into an agreement of any kind, whether oral or written, with respect to a professional license, in lieu of or in order to avoid formal disciplinary action, with any board, bureau, department, agency, or other body, including those in Ohio?	❑	❑
12.	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?	❑	❑
13.	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?	❑	❑
14.	Have you ever been denied, or have you ever surrendered, a state or federal controlled substance or drug registration; had it revoked, terminated, or restricted in any way; or been warned, reprimanded, or fined by, or been requested to appear before, the responsible agency?	❑	❑
15.	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? If yes, submit copies of all relevant documentation, such as police reports, ***certified*** court records and any institutional correspondence and orders. Photocopies will not be accepted.	❑	❑
16.	Have you ever been arrested, 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 filed against you (other than a malpractice suit)? If yes, submit copies of all relevant documentation, such as police reports, ***certified*** court records and any institutional correspondence and orders. Photocopies will not be accepted.	❑	❑
17.	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, you must complete the enclosed malpractice claim information form. 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.	❑	❑
18.	Have you ever been denied professional liability insurance or coverage, or had such insurance or coverage canceled, limited, or restricted in any way?	❑	❑
19.	Have you ever been denied or relinquished participation in any third party reimbursement program, whether governmental or private, including Medicaid and Medicare; or had such participation limited, restricted, suspended, or revoked; or been warned, reprimanded, requested to appear before, or fined by the responsible body?	❑	❑
20.	Have you ever been denied privileges, or had privileges revoked, suspended, restricted, reduced, or terminated by the Department of Defense, the Veteran's Administration, or any of their respective components?	❑	❑

Applicant Name:_____ Date:_____

		YES	NO
21.	Have you ever been diagnosed as having, or have you been treated for, pedophilia, exhibitionism, or voyeurism? If yes, please explain.	❑	❑
22. 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. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.

For purposes of questions 23 and 24 the following phrases or words have the following meaning:

"Ability to practice medicine" 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
23.	Do you have, or have you been diagnosed as having, a medical condition which in any way impairs or limits your ability to practice medicine 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. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.

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.	❑	❑

"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
24.	Do you use chemical substance(s) which in any way impair or limit your ability to practice medicine 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. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.

	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 25 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
25.	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.	❑	❑

VISITING MEDICAL FACULTY CERTIFICATE
MEDICINE OR OSTEOPATHIC MEDICINE
MALPRACTICE CLAIM INFORMATION

This form must be competed if you have been named as a defendant in a malpractice lawsuit, verdict or settlement. *Make additional copies of this form as necessary for multiple claims.*

Name of Physician (print clearly):_____

MALPRACTICE COMPLAINT:

Name of Patient:_____

Patients Gender: ❑ Male ❑ Female Age of Patient:_____

Date of Incident:_____ Date Suit Filed:_____

Location of incident:_____
Hospital, institution or other

_____
Address

_____
City State Zip Code County

Name and Address of Involved Insurance Carrier:_____

_____

FILED AGAINST: ❑ Individual Physician ❑ Group ❑ Hospital

Your Position in Case: ❑ Resident ❑ Primary Physician ❑ Other:_____

List names of other defendant-physicians and/or hospitals:_____

_____

DISPOSITION: ❑ Pending ❑ Jury Verdict ❑ Settled ❑ Dismissed ❑ Dropped

If settled, provide the following information: ❑ In Court ❑ Out of Court

Name of Court:_____

Date of Settlement:_____ Docket #:_____

Total amount of settlement: $_____ Amount attributable to you: $_____

You must provide a detailed written explanation of the background and medical issues involved in the case. This must be described in your own words. Do not reference attached documentation. If additional space is needed, attach separate sheet. Submit copies of the complaint, answer, release, settlement documents and all other relevant legal documents. Be sure to have your malpractice insurance carrier(s) provide a complete claims history report.

_____

_____

_____

_____

_____

_____

_____

_____ _____
Physician's Signature Date

State Medical Board of Ohio

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VISITING MEDICAL FACULTY CERTIFICATE
MEDICINE OR OSTEOPATHIC MEDICINE
FORM 1 – VERIFICATION OF ACTIVITY

This form must be completed by the Dean and signed by the Medical Director of each affiliated teaching hospital. Indicate the specific staff appointment and dates of appointment. Return directly to the State Medical Board at the above address.

This is to certify that _____ has been appointed to the teaching staff at:
(name of applicant)

Name of Medical School:	
Medical School Address	Street Address City / State / Zip Code

Affiliated with the following teaching hospitals.

Name of Teaching Hospital (include address)	Signature of Hospital/Medical Director (print name legibly beneath)	Date
	Signature _____ Print name legibly	
	Signature _____ Print name legibly	
	Signature _____ Print name legibly	
	Signature _____ Print name legibly	

Effective From: mo/day/yr / / To: mo/day/yr / / **(DATES NOT TO EXCEED 3 YEARS)**

Shall perform the following duties as is incidental to his/her teaching duties in accordance with Section 4731.293. Ohio Revised Code.

Description
of Activity:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

SEND CONFIRMATION TO:

_____
Name

_____
Hospital/Institution

_____
Street Address

_____
City State Zip Code

_____
Signature of Dean

_____
Name (please print clearly)

_____
Telephone Number (include area code)

_____
Title

_____
Date

(MEDICAL SCHOOL SEAL)

VISITING MEDICAL FACULTY CERTIFICATE
MEDICINE OR OSTEOPATHIC MEDICINE
AFFIDAVIT AND RELEASE OF APPLICANT

The affidavit and release below MUST be completed by **ALL** applicants. The form must be notarized. Failure of any applicant to submit the affidavit completed and notarized with the application will result in your application being considered as incomplete.

ss STATE OF: _____

COUNTY OF: _____

I, _____, hereby certify under oath that I am the person named in this application for a visiting medical faculty certificate in the State of Ohio; that all statements I have made 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 general information and instructions for all applicants and that I have answered all questions in compliance with these instructions and understand that the fee I submitted is neither refundable nor transferable.

I further state that by filing this application for a visiting medical faculty certificate 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 a visiting medical faculty certificate. 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 my application for a visiting medical faculty certificate in the State of Ohio is an ongoing process. I will immediately notify the State Medical Board of Ohio in writing of any changes to the answers to any of the questions contained in the ADDITIONAL INFORMATION section of the application if such a change in an answer is warranted at any time prior to a visiting medical faculty certificate being granted to me by the State Medical Board of Ohio. I further understand that failure to complete this application as requested by the Board within six months can be considered abandonment of any request for a visiting medical faculty certificate and that any fee I submitted is neither refundable nor 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 to the issuance of a visiting medical faculty certificate.

I hereby release, discharge, and exonerate the State Medical Board of Ohio, its agents or representatives and any person, hospital, clinic, governmental agency (local, state, federal or foreign), court, association, institution, or law enforcement agency furnishing information, of 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 issuance of a visiting medical faculty certificate in Ohio will be considered on the truth of the statements and documents contained herein or to be furnished, which if false, can subject me to denial of said certificate.

_____
Signature of Applicant

Subscribed and sworn to before me this _____ day of _____ 20 _____.

_____
Signature of Notary Public

(NOTARY SEAL)

_____
Date Commission Expires