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 med.renewal@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: _____ Telephone number: _____

THIS SECTION TO BE COMPLETED BY EMPLOYER

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

Name of hospital/clinic 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? _____

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
Medical knowledge and techniques	1	2	3	4	5	6	7	8	9	10
Relationship with patients	1	2	3	4	5	6	7	8	9	10
Ability to work well with peers and medical 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