



**Section 2 - Osteopathic Programs Completed to Date**

I have completed the following osteopathic Category 1 activities specified in "Mandatory Continuing Medical Education Osteopathic," during the current biennium, which may be applied to the forty (40) hour Category 1 minimum.

Name of Activity	Location	Date	Category	Credit Hours
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**Section 3 - Reason(s) for Requesting Reclassification**

The reasons for making this request are: (check all that apply)

- (A) Circumstances require that I attend CME programs near my home and similar osteopathic programs are not available in Ohio or in the geographical area where I practice, that are relevant to my practice.
- (B) I am/was in a non-osteopathic internship, residency or fellowship program which is /was not approved by the American Osteopathic Association. (If checked, please complete Section 4.)
- (C) The courses sponsored by osteopathic organizations are not relevant to my practice in terms of subject matter because (please explain):
- (D) Other reasons for request (please describe as fully as possible):

**Section 4 - Credit for Non-AOA-Approved Training**

If you are seeking CME credit for a non-AOA-approved internship, residency or fellowship program, please complete the following information as fully as possible.

(A) Osteopathic college of graduation:

Date of graduation:

(B) Internship - Name of institution:

City:

State:

Date Started:

Date Completed:

AOA-approved:  Yes  No

AMA-approved:  Yes  No

(C) Residency - Type of residency:

City:

State:

Date Started:

Date Completed:

AOA-approved:  Yes  No

AMA-approved:  Yes  No

(D) Fellowship - Type of Fellowship:

City:

State:

Date Started:

Date Completed:

AOA-approved:  Yes  No

AMA-approved:  Yes  No

(E) Did you ever request AOA-approval for the internship/residency/fellowship program for which you are requesting certification as listed in question number 2?  Yes  No

(F) Please state reasons for entering a non-AOA-approved program:

**AFFIDAVIT\***

ss STATE OF  
COUNTY OF

Before me personally appeared  
who being duly sworn says that he/she is the person referred to in the foregoing request for Category  
1-C Continuing Medical Education credits; that the statements therein are strictly true in every  
respect; and that he/she has read and understands this Affidavit.

(Signature of Affiant)

(SEAL)

Subscribed and sworn to before me this            DAY            day of            MONTH            YEAR .

Signature of Official Administering Oath

**\*MUST BE SWORN TO BEFORE A NOTARY OR OTHER  
PERSON AUTHORIZED TO ADMINISTER OATHS**