

Name \_\_\_\_\_  
Ohio License No.: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

**AFFIDAVIT**

SS STATE OF  
COUNTY OF

On this \_\_\_\_\_ day of \_\_\_\_\_, 200\_\_\_\_, personally appeared before me a Notary Public,  
within and for the county and state aforesaid, \_\_\_\_\_ who being duly sworn  
name of licensee

says that he/she is the person referred to in the request for a duplicate identification card and duplicate wall  
certificate indicating eligibility to practice \_\_\_\_\_  
branch of practice (i.e., medicine and surgery, massage, cosmetic  
therapy, etc.)

in the State of Ohio. Said affiant further states that the reason for requesting a duplicate identification card  
and wall certification is as follows:

\_\_\_\_\_  
\_\_\_\_\_

Affiant further states that the statement herein contained is strictly true in every respect; that  
he/she is the person named in the original identification card and was the lawful possessor of the original  
identification card; and that if his/her identification card has been lost and is later found, he/she will return  
the original identification card to the State Medical Board.

NAME AS YOU PREFER  
IT INSCRIBED ON YOUR  
IDENTIFICATION CARD

\_\_\_\_\_  
LAST FIRST MIDDLE SUFFIX(JR.II)

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 200\_\_\_\_.

(NOTARY SEAL)

\_\_\_\_\_  
Notary Public Signature

\_\_\_\_\_  
Date Commission Expires

\_\_\_\_\_  
Signature of Applicant Date