State Medical Board of Ohio

30 E. Broad St., 3rd Floor
Columbus, Ohio 43215
(614) 466-3934
www.med.ohio.gov

RESPIRATORY CARE LIMITED PERMIT (L1)
Verification of Education

The State Medical Board of Ohio requires that this form be completed by the respiratory care educational program in which the applicant is enrolled and in good standing. Please complete this form and e-mail it to the State Medical Board of Ohio at license@med.ohio.gov.

THIS SECTION TO BE COMPLETED BY APPLICANT

Full Name: _____ DOB: _____

I hereby authorize the below-named program to furnish the information below to the State Medical Board of Ohio.

_____
Signature of Applicant

Date: _____

THIS SECTION TO BE COMPLETED BY RESPIRATORY CARE EDUCATIONAL PROGRAM

Name of School/Program: _____

Address: _____

Is the program accredited by the Commission on Accreditation for Respiratory Care and does it require a minimum of an associate degree with a major in respiratory care? Yes_____ No_____

Is the above-named applicant enrolled in and in good standing in the program? Yes_____ No_____

Initial date of the student's enrollment in the program (month/year): _____

Anticipated date of graduation (month/year): _____

I certify that the above-named individual is enrolled in and is in good standing in the above-named respiratory care educational program.

_____
Signature of Program Director

Name (Printed): _____ Date: _____