



### SPECIAL ACTIVITY CERTIFICATE APPLICATION

#### Verification of Activity

Email completed form directly to the State Medical Board at license@med.ohio.gov.

Applicant: \_\_\_\_\_  
Last First Middle Suffix (Jr., II)

Will be performing the special activity outlined below in accordance with Ohio Revised Code 4731.294 with

Hospital/Institution: \_\_\_\_\_

\_\_\_\_\_  
Hospital Street Address City State Zip Code

effective from \_\_\_\_\_ to \_\_\_\_\_ \*Date range may **not** exceed 30 days.  
Month/Day/Year Month/Day/Year

Description of special activity:

I hereby certify that the information contained herein is true, accurate and complete to the best of my knowledge, information and belief.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Email

\_\_\_\_\_  
Phone