

The Ohio State University College of Medicine

Med 3-4 Academic Program

Visiting Student Self-Disclosure

Student Name: _____

Institution: _____

If you answer "YES" to any of the following questions*, you are required to furnish complete details, including date, place, reason and disposition of the matter. All affirmative answers must be thoroughly explained on a separate sheet of paper. Please note that some questions require very specific and detailed information. Make sure all responses are complete.

*These questions have been modified from the application for training certificate in the medicine or osteopathic medicine from the State Medical Board of Ohio.

1.	<p>Have you ever been convicted or found guilty of a violation of any law, regardless of the legal jurisdiction in which the act was committed, other than a minor traffic violation? [Note: DUI is not considered a minor traffic violation.]</p> <p><i>Please be advised that you are required to submit copies of all relevant documentation, such as police records, certified court records and any institutional correspondence and orders.</i></p>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
2.	<p>Have you ever forfeited collateral, bail, or bond for breach or violation of any law, police regulation, or ordinance other than for a minor traffic violation; been summoned into court as a defendant or had any lawsuit filed against you (other than a malpractice suit)? [Note: DUI is not considered a minor traffic violation.]</p> <p><i>Please be advised that you are required to submit copies of all relevant documentation, such as police records, certified court records and any institutional correspondence and orders.</i></p>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
3.	<p>Have you ever been diagnosed as having, or have you been treated for, pedophilia, exhibitionism, or voyeurism?</p>	YES <input type="checkbox"/>	NO <input type="checkbox"/>

If you answer "YES" to either question 4 or 5, please provide details on a separate sheet, including date(s) of diagnosis or treatment, and a description of your present condition. Include the name, current mailing address, and telephone number of each person who treated you, as well as each facility where you received treatment, diagnosis and prognosis.

4.	<p>Within the last ten years, have you been diagnosed with or have you been treated for, bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?</p>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
5.	<p>Have you, since attaining the age of eighteen or within the last ten years, whichever period is shorter, been admitted to a hospital or any other facility for the treatment of bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?</p>	YES <input type="checkbox"/>	NO <input type="checkbox"/>

For the purposes of questions 6 and 7 the "ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgements and to learn and keep abreast of medical developments; and

2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

3. The physical capability to perform medical tasks, such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.		
6.	Do you have, or have you been diagnosed as having, a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?	YES NO <input type="checkbox"/> <input type="checkbox"/>
6a.	Are the limitations or impairment caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program?	YES NO <input type="checkbox"/> <input type="checkbox"/>
For the purpose of question 7 "chemical substances" is to be construed to include alcohol, drugs, or medications including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.		
7.	Do you use chemical substance(s) which in any way impair or limit your ability to practice medicine with reasonable skill and safety?	YES NO <input type="checkbox"/> <input type="checkbox"/>
7a.	Are the limitations or impairment caused by your use of chemical substances reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program?	YES NO <input type="checkbox"/> <input type="checkbox"/>
For the purpose of question 8 the following phrases or words have the following meaning:		
"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a healthcare provider, or within the past two years.		
"Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed healthcare practitioner.		
8.	Are you currently engaged in the illegal use of controlled substances?	YES NO <input type="checkbox"/> <input type="checkbox"/>
8a.	If "YES", are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not using illegal controlled substances?	YES NO <input type="checkbox"/> <input type="checkbox"/>

I warrant that all of the information that I have provided and the responses that I have given are correct and complete to the best of my knowledge and belief. I understand that willful falsification or willful omission of this information will be grounds for rejection or dismissal.

Signature

Return form to:

Med 3-4 and Visiting Student Program
333 W. 10th Ave
B013 Graves Hall
Columbus, OH 43212