



STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

44-23-63
3-30-9
365.00
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216.3

APPLICATION FOR CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE

PLEASE TYPE OR PRINT CLEARLY

1. Social Security Number:

Redacted		
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2. Full Name
(Use no initials):

LAST (Surname)	FIRST	MIDDLE	SUFFIX(Jr., II)
BEECH	AMY	LEIGH	

3. Name (As you prefer it
inscribed on your
Ohio license):

LAST (Surname)	FIRST	MIDDLE	SUFFIX(Jr., II)
BEECH	AMY	STEARNS	

4. Maiden Name Or
Other Names Used
(If none, enter "NONE"):

LAST (Surname)	FIRST	MIDDLE	SUFFIX(Jr., II)
STEARNS	AMY	LEIGH	

14. Have you ever been a patient (voluntary or otherwise) in any institution for the treatment of emotional or mental illness, drug addiction or abuse, or an alcohol problem? If yes, you must have your treating physician(s) submit a letter directly to the Board on your behalf summarizing dates of treatment, etc.

☐ ☒

15. Have you ever been treated but not hospitalized for emotional or mental illness, drug addiction or abuse, or an alcohol problem? If yes, you must have your treating physician(s) submit a letter directly to the Board on your behalf summarizing dates of treatment, etc.

☒ ☐

16. Have you ever been denied, or surrendered, a state or federal controlled substance or drug registration; had it revoked, terminated, or restricted in any way; or been warned, reprimanded, or fined by, or been requested to appear before, the responsible agency?

☐ ☒

TO BE COMPLETED BY HOSPITAL OR TRAINING INSTITUTION

I offer the following in support of his/her application for full licensure:

I rate his/her medical knowledge and technique as: INSUFFICIENT

His/her relationship with patients is: GOOD

I rate his/her ability to work well with peers and medical staff as: GOOD

His/her command of the English language is: Excellent

Additional comments: ONLY SUPERVISED FOR 4 mos.

OVER ➡

This certifies that Amy Beech has successfully completed
(name of applicant)

60 weeks
not less than 4 months of graduate medical education through the: ☒ 1st year level
☐ 2nd year level
☐ 3rd year level or above

as a(n): ☒ intern
☐ resident in Pediatrics
☐ clinical fellow (department)

Albert Einstein College of Medicine and
at Montefiore Medical Center 111 E. 210th St., Bronx, NY 10467
(name of hospital) (complete street address of hospital)

from July 1, 1990 to October 31, 1990
beginning (mo/day/yr) ending (mo/day/yr)

It is further certified that the above named: ☐ will be awarded a certificate on mo/day/yr
☐ was awarded a certificate on mo/day/yr
☒ was not awarded a certificate
please explain: left the program

and that the training: ☒ was accredited by ACGME/AOA
☐ was not accredited by ACGME/AOA

I hereby recommend him/her for full licensure to practice in the State of Ohio.

(SEAL OF HOSPITAL)* _____

*If hospital has no seal, please indicate
and have form notarized.

Steven P. Shelov
Signature of Medical Director or Program Director
(Original signature only, names stamps will not be
accepted)

Steven P. Shelov, MD
Name (please print or type)

5/5/94
Date