OHIO DEPARTMENT OF PUBLIC SAFETY
DIVISION OF EMERGENCY MEDICAL SERVICES

PHYSICIAN EMS INSTRUCTOR OR PHYSICIAN CONTINUING EDUCATION INSTRUCTOR INITIAL APPLICATION

Incomplete applications WILL NOT be processed.

Required fields, denoted by an asterisk (*), must be completed.
(Please print legibly and use black or blue ink.)

The purpose of this form is to apply for an initial Physician EMS Instructor or Physician Continuing Education Instructor certificate to teach. For information on certification requirements, please visit our webpage at www.ems.ohio.gov.

LEGAL LAST NAME*	LEGAL FIRST NAME*	LEGAL MI	SUFFIX

HOME ADDRESS (STREET)*	P.O. BOX

CITY*	STATE*	ZIP CODE*	COUNTY OF RESIDENCE

HOME PHONE NUMBER	WORK PHONE NUMBER	CELL PHONE NUMBER

E-MAIL ADDRESS*	SECONDARY E-MAIL ADDRESS

SOCIAL SECURITY NUMBER*	Disclosure of social security # is mandatory pursuant to Ohio Revised Code (R.C.) 3123.50 in furtherance of licensing provision and any other state or federal requirements.	DATE OF BIRTH*	LICENSE / CERTIFICATE NUMBER*

ARMED FORCES INFORMATION* **Mark at least one response.**

Using the definition of armed forces provided, check all that apply and provide information requested.

"Armed forces" means the armed forces of the United States, including the army, navy, air force, marine corps, coast guard, or any reserve components of those forces; the national guard of any state; the commissioned corps of the United States public health service; the merchant marine service during wartime; such other service as may be designated by congress; or the Ohio organized militia when engaged in full-time national guard duty for a period of more than thirty days. (R.C. section 5903.01)

☐ I am a veteran of the armed forces, discharged / released under honorable conditions.
Year of discharge / release _____

☐ I am a current member of the armed forces.

☐ I am a spouse of a current member of the armed forces or a veteran, discharged / released under honorable conditions.
Year of veteran's discharge / release _____

☐ I am a surviving spouse of a service member or veteran, discharged / released under honorable conditions.
Year of veteran's discharge / release _____

☐ None of the above.

You must answer the following questions for your application to be considered:*

1. Do you have any charges pending or have a conviction for a felony or a misdemeanor (other than minor traffic violation)? * ☐ Yes ☐ No
2. Is your license to practice medicine currently under any disciplinary sanctions?* ☐ Yes ☐ No

If you answered "Yes" to either of these questions, complete the Declaration of Criminal History portion on Page 3 of this application.

PHYSICIAN CONTINUING EDUCATION INSTRUCTOR QUALIFICATIONS

- Must hold an Ohio medical training certificate as a physician, which is in good standing; and
- Must be recommended by the local Regional Physicians Advisory Board or recommended by the program director or medical director of an accredited or approved training institution.

*Required field which must be completed

PHYSICIAN EMS INSTRUCTOR QUALIFICATIONS

- Must hold an Ohio license to practice medicine and surgery or osteopathic medicine and surgery, which is in good standing; and
- Must be an active medical director with an EMS agency; recommended by the local Regional Physicians Advisory Board; or recommended by the program director or medical director of an accredited or approved training institution.

SELECT THE QUALIFICATION WHICH BEST APPLIES:

☐ I am an active EMS Medical Director, as set forth in Ohio Administrative Code (O.A.C.) 4765-3-05, with the following agency (Physician EMS Instructor Only)

NAME OF AGENCY	NAME OF AGENCY HEAD

SIGNATURE OF DEPARTMENT OR AGENCY HEAD	DATE
X	

☐ I am being recommended by a Regional Physician Advisory Board (RPAB).

NAME OF RPAB CHAIR	REGION NUMBER

SIGNATURE OF RPAB CHAIR	DATE
X	

☐ I am being recommended by a Program Director of an Accredited or Approved Training Institution.

NAME OF ACCREDITED OR APPROVED TRAINING INSTITUTION	

NAME OF PROGRAM DIRECTOR OR PROGRAM MEDICAL DIRECTOR	CERTIFICATE NUMBER

SIGNATURE OF PROGRAM DIRECTOR OR PROGRAM MEDICAL DIRECTOR	DATE
X	

ATTESTATION:

I attest that all information provided is true and accurate to the best of my knowledge. I understand that a false statement on this application may constitute falsification under Section 2921.13 of the R.C. and is a misdemeanor of the first degree. Any false statement may also be grounds for denial, suspension, revocation, or other disciplinary action taken against my certificate as determined by the Ohio State Board of Emergency Medical, Fire, and Transportation Services (EMFTS). I further attest that I satisfy all requirements for a certificate at the level sought in this application as set forth in Section 4765.23 of the R.C. and O.A.C. Chapter 4765-18. I am solely responsible for my certificate. I understand that I must maintain records relating to the requirements for continuing education and instructional renewal requirements. Such records are subject to audit by the Division of EMS, as directed by the Ohio State Board of EMFTS. I hereby give permission to the Ohio Department of Public Safety, Division of EMS to verify any of the above information.

SIGNATURE OF APPLICANT	DATE
X	

Return To:

OHIO DEPARTMENT OF PUBLIC SAFETY
DIVISION OF EMERGENCY MEDICAL SERVICES
1970 West Broad St., P.O. Box 182073
Columbus, OH 43218-2073

Any questions please contact us at:

(800) 233-0785 OR FAX: (614) 466-9461

*Required field which must be completed

DECLARATION OF CRIMINAL HISTORY

INSTRUCTIONS: All Information MUST be included. Print legibly and use black or blue ink. Complete the form in its entirety pursuant to R.C. 4765.

LEGAL LAST NAME*	LEGAL FIRST NAME*	LEGAL MIDDLE INITIAL	SUFFIX

CRIMINAL HISTORY INFORMATION*

CRIMINAL CONVICTION	COURT WHERE CONVICTION OCCURRED	CONVICTION DATE	CONVICTION MISDEMEANOR / FELONY LEVEL	ARRESTING LAW ENFORCEMENT AGENCY

I. If you have been convicted of any felony, a misdemeanor committed in the course of practice, or a misdemeanor involving moral turpitude, you shall provide the Division of Emergency Medical Services with all of the following:*

1. **A civilian background check from the Bureau of Criminal Identifications & Investigations (BCI&I);**
2. **Certified copy of the police or law enforcement agency report, if applicable; and**
3. **Certified copy of the judgment entry from the court in which the conviction occurred.**

II. If you have previously disclosed any of the above information to the Division of EMS, please explain below to include when you reported the conviction(s) and submitted to the Division of EMS the information included in item numbered (I) and disposition taken by the Ohio State Board of Emergency Medical, Fire, and Transportation Services.*

III. Provide an explanation for the suspension, revocation, or other disciplinary sanction(s) issued against your certificate(s) to include the name of the agency that took the disciplinary action and the date the action was taken.*

ATTESTATION

I affirm that I have not been convicted of any other felony or misdemeanor other than the one(s) disclosed herein. I attest that all information provided is true and accurate to the best of my knowledge. I understand that a false statement on this application may constitute falsification under Section 2921.13 of the R.C. and is a misdemeanor of the first degree. Any false statement may also be grounds for denial, suspension, revocation, or other disciplinary action taken against my certificate as determined by the Ohio State Board of Emergency Medical, Fire, and Transportation Services (EMFTS). I am solely responsible for my certificate. I hereby give permission to the Ohio Department of Public Safety, Division of EMS to verify any of the above information.

APPLICANT'S SIGNATURE *	DATE
X	

*Required field which must be completed