



OHIO DEPARTMENT OF PUBLIC SAFETY  
EMERGENCY MEDICAL SERVICES

**PHYSICIAN EMS INSTRUCTOR – RENEWAL APPLICATION**  
(Ohio Administrative Code 4765-18-09)

**INFORMATION**

LEGAL LAST NAME		LEGAL FIRST NAME		LEGAL MI
HOME ADDRESS			P.O. BOX	
CITY		STATE	ZIP CODE	COUNTY
HOME PHONE NUMBER ( ) -	WORK PHONE NUMBER ( ) -	FAX NUMBER ( ) -		
SOCIAL SECURITY NUMBER / /	Disclosure of social security number is mandatory pursuant to R.C. 3123.50 in furtherance of licensing provision and any other state or federal requirements			DATE OF BIRTH
ORGANIZATION AFFILIATION	LICENSE NUMBER	E-MAIL ADDRESS		

**YOU MUST INDICATE WHICH CRITERIA YOU FULFILL FOR CERTIFICATION AS AN EMS INSTRUCTOR**

<input type="checkbox"/> I am an active EMS Medical Director, who meets the requirements as set forth in rule 4765-3-05, with the following agency(s)	
NAME OF DEPARTMENT OR AGENCY HEAD	NAME OF AGENCY
SIGNATURE OF DEPARTMENT OR AGENCY HEAD <b>X</b>	DATE
<input type="checkbox"/> I am being recommended by a Regional Physician Advisory Board (RPAB)	
NAME OF RPAB CHAIR	REGION NUMBER
SIGNATURE OF RPAB CHAIR <b>X</b>	DATE
<input type="checkbox"/> I am being recommended by the Program Director or Program Medical Director of an Accredited or Approved Training Institution	
NAME OF PROGRAM DIRECTOR OR PROGRAM MEDICAL DIRECTOR	NAME OF ACCREDITED/APPROVED TRAINING INSTITUTION
SIGNATURE OF PROGRAM DIRECTOR OR PROGRAM MEDICAL DIRECTOR <b>X</b>	DATE
1. Do you hold a current and valid Ohio license to practice medicine and surgery or osteopathic medicine and surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Are you in compliance with rule 4765-8-01 (A)(6) to (12) of the Ohio Administrative Code? <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Have you been convicted of, pled guilty to, had a judicial finding of guilt for, or had a judicial finding of eligibility for treatment and/or intervention in lieu of conviction for a felony or misdemeanor (other than a minor traffic violation)? <input type="checkbox"/> Yes <input type="checkbox"/> No If you answered yes to question 3, you must complete the second page of this form. 4. Is your Ohio license to practice medicine currently under any disciplinary action? <input type="checkbox"/> Yes <input type="checkbox"/> No If you answered yes to question 4, please explain below.	
I attest that all information provided is true and accurate to the best of my knowledge and I understand that a false statement on this application constitutes falsification under Section 2921.13 of the Ohio Revised Code and is a misdemeanor of the first degree and may also be grounds for denial, suspension or revocation of my certificate to teach. I further attest that I satisfy the requirements for a certificate to teach at the level sought in this application as set forth in 4765.23 of the Ohio Revised Code and Chapter 4765-18 of the Ohio Administrative Code and I am solely responsible for my certificate to teach. I hereby give permission to the Division of Emergency Medical Services to verify any of the above information.	
APPLICANT SIGNATURE <b>X</b>	DATE

**CRIMINAL HISTORY INFORMATION**

CRIMINAL CONVICTION	COURT WHERE CONVICTION OCCURRED	CONVICTION DATE	LEVEL OF CONVICTION MISDEMEANOR/FELONY	ARRESTING POLICE AGENCY

I. If you have been convicted of, pled guilty to, had a judicial finding of guilt for, or had a judicial finding of eligibility for treatment and/or intervention in lieu of conviction for any felony, a misdemeanor committed in the course of practice, misdemeanor involving moral turpitude, a violation of any federal, state, county, or municipal narcotics or controlled substance law since your last or renewal/ initial application, you shall provide the Division of Emergency Medical Services (EMS) with 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.**
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 submitted to the Division of EMS the information included in item numbered (I) and disposition taken by the State Board of Emergency Medical Services.

**EMS APPLICANTS**

I affirm that I have not been convicted of, pled guilty to, had a judicial finding of guilt for, or had a judicial finding of eligibility for treatment and/or intervention in lieu of conviction for, 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 constitutes falsification under Section 2921.13 of the Ohio Revised Code 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 to practice as determined by the State Board of EMS. I am solely responsible for my certificate to practice. I hereby give permission to the Division of Emergency Medical Services to verify any of the above information.

APPLICANT SIGNATURE <b>X</b>	DATE
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**Return To:**  
 Ohio Department of Public Safety  
 Emergency Medical Services  
 1970 West Broad Street  
 P.O. Box 182073  
 Columbus, OH 43218-2073  
 Phone: (800) 233-0785 or (614) 466-9447  
 Fax: (614) 995-7012 or (614) 466-9461