



INITIAL APPLICATION FOR CERTIFICATE OF APPROVAL

RETURN COMPLETED APPLICATION TO:

**DIVISION OF EMERGENCY MEDICAL SERVICES
PO BOX 182073
COLUMBUS, OH 43218-2073**

GENERAL PROGRAM CONTACT INFORMATION *(Please type or print legibly)*

PROGRAM NAME <i>(Note: name of organization must match the name on the certificate)</i>			
PROGRAM ADDRESS			
STREET ADDRESS			
CITY	STATE	ZIP	COUNTY
PROGRAM MAILING ADDRESS <i>(If different from street address)</i>			
PROGRAM E-MAIL ADDRESS OR WEBSITE			

***AUTHORIZING OFFICIAL INFORMATION**

* This person has signature authority for the organization and either owns, or maintains responsibility, on behalf of the organization.	
NAME	
TELEPHONE NUMBER	FAX NUMBER
E-MAIL ADDRESS	

PROGRAM COORDINATOR INFORMATION

NAME	
TELEPHONE NUMBER	FAX NUMBER
E-MAIL ADDRESS	
EMS CERTIFICATION LEVEL & NUMBER	INSTRUCTOR LEVEL

MEDICAL DIRECTOR INFORMATION

NAME	
LICENSE NUMBER	SPECIALTY
TELEPHONE NUMBER	FAX NUMBER
E-MAIL ADDRESS	
HOSPITAL AFFILIATION	

• **All courses offered through a training program shall be developed under the direction of a physician who specializes in emergency medicine. Each course that deals with trauma care shall be developed in consultation with a physician who specializes in trauma surgery. [O.A.C. 4765-7-09(A)(2)(f)]; [O.R.C. 4765.16(A)]**

• **The applicant must have a program medical director who assumes responsibility for the medical components of the program. [O.A.C. 4765-7-09(A)(3)]**

Is your program medical director a licensed physician who specializes in emergency medicine?

YES NO

Does your medical director hold a certificate to teach EMS?

YES NO If yes, list certification number

Does your department have access to a physician that specializes in trauma surgery?

YES NO

Will the medical director be active within the program?

YES NO

Describe the role your program medical director serves with the training program.

• **The applicant must have a program coordinator who assumes general responsibility for administering and operating the program. [O.A.C. 4765-7-09(A)-(J)]**

Please give a brief overview of your department, including number of personnel, certification levels, number of EMS runs per year or per month, size of area served, and number of transporting ambulances. Include population size and square miles.

INSTRUCTORS

• **Instruction must be provided by instructors who hold a certificate to teach issued under section 4765.23 of the revised code that is appropriate to the level of courses to be taught. [O.A.C. 4765-7-09(A)(4)&(5); O.A.C. 4765-18; O.R.C. 4765.16]**

LIST THE INSTRUCTORS WHO WILL BE UTILIZED IN YOUR PROGRAM *(Copy page, if additional space is needed)*

NAME	NAME
INSTRUCTOR CERTIFICATION NUMBER	INSTRUCTOR CERTIFICATION NUMBER
<input type="checkbox"/> INSTRUCTOR <input type="checkbox"/> ASST. INST. <input type="checkbox"/> C.E. INST.	<input type="checkbox"/> INSTRUCTOR <input type="checkbox"/> ASST. INST. <input type="checkbox"/> C.E. INST.
NAME	NAME
INSTRUCTOR CERTIFICATION NUMBER	INSTRUCTOR CERTIFICATION NUMBER
<input type="checkbox"/> INSTRUCTOR <input type="checkbox"/> ASST. INST. <input type="checkbox"/> C.E. INST.	<input type="checkbox"/> INSTRUCTOR <input type="checkbox"/> ASST. INST. <input type="checkbox"/> C.E. INST.
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• **The applicant must have sufficient classroom and laboratory facilities to accommodate the number of participants in each course. [O.A.C. 4765-7-09(A)(10); O.A.C. 4765-7-05]**

Estimate the number of course offerings to be provided annually and the average number of participants you anticipate will attend:

Has the program coordinator determined that all of the facilities which will be utilized are of adequate size to accommodate the number of students who will be participating in the courses? [O.A.C. 4765-7-09(a)(10)]

YES NO

Has the program coordinator visited all of the facilities which will be utilized to ensure that the facility is safe, sanitary, and conducive to learning? [O.A.C. 4765-7-09(a)(11)]

YES NO

LIST ALL SITES TO BE USED FOR COURSE OFFERINGS. *(Copy page, if additional space is needed)*

SITE NAME	SITE ADDRESS
SITE NAME	SITE ADDRESS
SITE NAME	SITE ADDRESS
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SITE NAME	SITE ADDRESS
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SITE NAME	SITE ADDRESS
SITE NAME	SITE ADDRESS
SITE NAME	SITE ADDRESS

• **Students at each course must complete a course assessment or evaluation form.**
[O.A.C. 4765-7-09(A)(14)]

• **The applicant must issue a certificate of completion to each participant who completes the course.**
[O.A.C. 4765-7-09(A)(2)(h); O.A.C. 4765-7-11(D)]

Attach a copy of the program assessment and/or evaluation form that will be provided to each attendee at the end of each program.

Attach a copy of the certificate to be issued to each participant. [The certificate should include the training program name (and approval number once issued); title/topic of course; total number of hours of CE awarded for course; breakdown of pediatric, geriatric, trauma, and cardiac hours; date of course; name of participant; program coordinator's signature line].

The applicant must maintain paper or electronic records for each course that documents the following:

- 1) Title and date(s) of course;
- 2) Course starting and ending times;
- 3) Lesson materials and a copy of each knowledge and/or skill evaluation instrument used;
- 4) Documentation of physician approval of course medical content;
- 5) Course attendance records;
- 6) Test records (for refresher courses, online courses, and distance learning courses);
- 7) Summary of student evaluations;
- 8) Name and credentials of each instructor;
- 9) Written agreements with each organization that provides resources.

[O.A.C. 4765-7-09(D); O.A.C. 4765-7-11; O.A.C. 4765-19-01]

Which type of records will you utilize?

Paper Electronic

Where will course files be maintained?

Who will have access to these files?

Describe how and what records will be maintained [reference O.A.C. 4765-7-09(d)]:

AUTHORIZING OFFICIAL SIGNATURE REQUIRED

I attest that the information included in this application is true and accurate to the best of my knowledge. As the Authorizing Official, I recognize that I am responsible for ensuring that all laws and rules pertaining to a Certificate of Approval (including any duties delegated to the Program Coordinator or Medical Director) are followed. I agree to provide a copy of this application to the Program Coordinator and Medical Director listed on page 1, as well as, any new Program Coordinator and/or Medical Director who may be assigned during the approval cycle.

SIGNATURE OF AUTHORIZING OFFICIAL X	DATE
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READ AND RECEIVED

SIGNATURE OF PROGRAM COORDINATOR X	SIGNATURE OF PROGRAM MEDICAL DIRECTOR X
PRINTED NAME	PRINTED NAME
DATE	DATE