



OHIO DEPARTMENT OF PUBLIC SAFETY
EMERGENCY MEDICAL SERVICES

ASSISTANT EMS INSTRUCTOR – INITIAL APPLICATION

LEGAL LAST NAME		LEGAL FIRST NAME		LEGAL MI
HOME ADDRESS (STREET)			P.O. BOX	
CITY		STATE	ZIP CODE	COUNTY OF RESIDENCE
HOME PHONE	WORK PHONE		E-MAIL ADDRESS	
SOCIAL SECURITY # / /	Disclosure of social security # is mandatory pursuant to R.C. 3123.50 in furtherance of licensing provision and any other state or federal requirements		DATE OF BIRTH	OHIO EMT CERTIFICATE #
YOUR CURRENT LEVEL OF CERTIFICATION/LICENSE <input type="checkbox"/> First Responder <input type="checkbox"/> EMT-Intermediate <input type="checkbox"/> Registered Nurse License # _____ <input type="checkbox"/> EMT-Basic <input type="checkbox"/> EMT-Paramedic <input type="checkbox"/> Physician Assistant License # _____				
EDUCATIONAL INSTITUTION AFFILIATION (IF ANY)				
INSTITUTION ADDRESS			P.O. BOX	
CITY		STATE	ZIP CODE	
INSTRUCTOR TRAINER	TRAINER CERTIFICATION #		DATE OF TRAINING COMPLETION	
THE APPLICANT HAS MET THE FOLLOWING CRITERIA 1. In the preceding five (5) years have you been certified/licensed for at least three (3) years as a First Responder, EMT, Registered Nurse, or Physician Assistant? <input type="checkbox"/> Yes <input type="checkbox"/> No				
2. Within the preceding three (3) years, have you passed the knowledge exam? <input type="checkbox"/> Yes <input type="checkbox"/> No Date completed: ____/____/____ Level of Exam: _____				
3. Within the preceding three (3) years, have you passed the practical exam? <input type="checkbox"/> Yes <input type="checkbox"/> No Date completed: ____/____/____ Level of Exam: _____				
4. Have you completed the eight (8) hours in instruction specific to the field of emergency medical services, as outlined in rule 4765-18-04 of the Ohio Administrative Code? <input type="checkbox"/> Yes <input type="checkbox"/> No Date completed: ____/____/____				
5. Have you completed ten (10) hours of supervised teaching in the presence of an EMS instructor, under the auspices of an accredited institution? <input type="checkbox"/> Yes <input type="checkbox"/> No				
6. 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				
7. Do you, as the person accepting responsibility by signing this form, have charges pending or have a conviction for a felony or a misdemeanor (other than a minor traffic violation), or a judicial finding of eligibility for treatment in lieu of conviction. <input type="checkbox"/> Yes <input type="checkbox"/> No				
8. Has your EMS certificate to practice or certificate to teach, in this or any other state, ever been suspended or revoked? <input type="checkbox"/> Yes <input type="checkbox"/> No If you answered yes to questions 7 or 8 above, you must complete the second page of this form.				
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 understand that I must maintain records relating to the renewal requirements for this certificate and that such records are subject to audit by the State Board of EMS. I hereby give permission to the Division of Emergency Medical Services to verify any of the above information.				
APPLICANT'S SIGNATURE X			DATE	
I attest that I am the authorized Program Director for the accredited institution listed below. The above named applicant has met all requirements, set forth in Chapter 4765-18, through an accredited institution for a certificate to teach as an EMS instructor.				
PROGRAM DIRECTOR'S SIGNATURE X			DATE	
EMS ACCREDITED INSTITUTION			ACCREDITATION #	

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:

III. Please provide an explanation for the suspension or revocation of your certificate to practice, or certificate to teach, and the date the action was taken:

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'S SIGNATURE X	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