

Ohio Public Safety
Division of Emergency Medical Services
Intermediate Transition Course Verification Form

Student Certification Number: _____

Student Name: _____

Student 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.

Instructor Certification Number: _____

Instructor Name: _____

Class Start Date: _____ **Class End Date:** _____

I attest that I am the authorized Program Coordinator for the accredited school named below and that the above named student successfully completed the required Intermediate Transition Course in accordance with the Ohio Administrative Code and that the above named instructor was certified in accordance with the Ohio Administrative Code at the time of this class to teach all required materials.

Program Coordinator's Signature: _____

Program Coordinator's Name (Print): _____

Name of Accredited School: _____

Accreditation Number: _____

Please return all completed forms to:
Ohio Public Safety
Division of Emergency Medical Services
1970 West Broad Street, P.O. Box 182073
Columbus, Ohio 43218-0273