



## Application for Certificate of Approval

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**Return Completed Application to:**

**Division of Emergency Medical Services  
P. O. Box 182073  
Columbus, OH 43218-2073**

**General Program Contact Information**

*(Please Type or Print Legibly)*

Program Name: *(Note: name of organization must match the name on the certificate)*

Program Address:

Street Address

City

State

Zip

County

Program Mailing Address (if different from street address):

**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: .....

**Medical Director Information**

**Program Medical Director Information:**

Name: .....

License #: ..... Specialty: .....

Telephone Number: ..... Fax Number: .....

E-mail address: .....

The applicant must have a program coordinator who assumes general responsibility for administering and operating the program. [ O.A.C. 4765-7-09 (B) (1) ]

Describe the duties of the program coordinator:

The applicant must have a program medical director who assumes responsibility for the medical components of the program. [ O.A.C. 4765-7-09 (B) (2) ]

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.R.C. 4765.16 (A) ]

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

Does your medical director hold a certificate to teach EMS?

(If yes, list cert # \_\_\_\_\_)

Describe the role the program medical director will serve:

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 programs to be taught. [ O.A.C. 4765-7-09 (B) (3); 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)

EMS Instructors

Special Topic Instructors

Name:

Name:

Instr. Cert #:

Instr. Cert #:

Name:

Name:

Instr. Cert #:

Instr. Cert #

The applicant must have sufficient classroom and laboratory facilities to accommodate the number of participants in each program. [ O.A.C. 4765-7-09 (B) (4) ]

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

List all sites to be used for course offerings, including a brief description of the facility and the number of participants the classroom will accommodate in classroom style: (copy page if additional space is needed)

Site Name: Capacity:  
Site Address:

Description:

Site Name: Capacity:  
Site Address:

Description:

Site Name: Capacity:  
Site Address:

Description:

Attendees at each program must complete a program assessment and evaluation form.  
[ O.A.C. 4765-7-09 (B) (5) ]

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

The applicant must issue a certificate of completion to each participant who completes the program. [ O.A.C. 4765-7-09 (B) (6) ]

\*\*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, number of hours of CE awarded for course, date of course, name of participant, program coordinator's signature line*]

The applicant must maintain records for each program that documents the following:  
1) date, time, location, and topic; 2) name and credentials of each instructor; 3) list of participants; 4) summary of the evaluations forms. [ O.A.C. 4765-7-09 (C) ]

Where will program files be maintained?

Who will have access to these files?

Describe how and what records will be maintained.

**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.

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Signature of Authorizing Official

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Date

**Read and Received:**

Program Coordinator:

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Signature

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Print Name

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Date

Program Medical Director:

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Signature

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Print Name

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Date