OHIO DEPARTMENT OF PUBLIC SAFETY
DIVISION OF EMERGENCY MEDICAL SERVICES

REQUEST FOR REPLACEMENT CARD

All Information **MUST** be included. Incomplete forms **WILL NOT** be processed.
(Please print legibly and use black or blue ink)

LEGAL LAST NAME	LEGAL FIRST NAME		LEGAL MIDDLE INITIAL
SOCIAL SECURITY #	Disclosure of social security number is mandatory pursuant to Ohio Revised Code 3123.50 in furtherance of licensing provision and any other state or federal requirements.		
ADDRESS	CITY	STATE	ZIP CODE
CERTIFICATION #	COUNTY OF RESIDENCE		
PRIMARY E-MAIL ADDRESS	SECONDARY E-MAIL ADDRESS (optional)		
HOME PHONE	WORK PHONE	CELL PHONE	

CARDS REQUESTED

☐ EMR (FR)	☐ EMT (EMT-B)	☐ AEMT (EMT- I)	☐ Paramedic (EMT-P)
☐ CE Instructor	☐ EMS Instructor	☐ Assistant Instructor	☐ EMSI Physician
☐ Vol. Fire	☐ FF1	☐ FF2	☐ Fire Safety Inspector
☐ Fire Instructor	☐ Fire Safety Insp. Instructor		

By submitting this form I attest that I am the individual named above and I authorize the Division of EMS to issue and mail the certification card or card requested.

PRINT NAME	
SIGNATURE **X**	DATE

Sign and Return To:

Ohio Department of Public Safety
Division of EMS
1970 West Broad Street
P.O. Box 182073
Columbus, OH 43218-2073
or
Fax to: (614) 466-9461

EMS 0079 12/14 [760-0984]