



OHIO DEPARTMENT OF PUBLIC SAFETY
DIVISION OF EMERGENCY MEDICAL SERVICES

**REGIONAL PHYSICIAN ADVISORY BOARD
MEMBERSHIP APPLICATION**

PLEASE PRINT OR TYPE IN BLACK OR BLUE INK

LAST NAME	FIRST NAME	MI	PHONE NUMBER () -	E-MAIL ADDRESS	
STREET ADDRESS			CITY	STATE	ZIP CODE
RPAB REGION		COUNTY / REGION OF WORK		COUNTY / REGION OF RESIDENCE	
<input type="checkbox"/> MD	<input type="checkbox"/> DO	OHIO PHYSICIAN LICENSE NUMBER:			EXPIRATION DATE

MEDICAL SPECIALTY (Check all that apply)

<input type="checkbox"/> Emergency Medicine	<input type="checkbox"/> Trauma	<input type="checkbox"/> Family Practice	<input type="checkbox"/> Surgery
<input type="checkbox"/> Pediatrics	<input type="checkbox"/> Internal Medicine	<input type="checkbox"/> Other (please explain)	

EDUCATION

MEDICAL SCHOOL		
RESIDENCY		
FELLOWSHIP		
YEARS IN PRACTICE	BOARDED	ORGANIZATION ISSUING BOARD CERTIFICATION

LEADERSHIP / MANAGEMENT POSITIONS (Include years)
EMS RELATED POSITIONS (Include years)
MAIN HOSPITAL AFFILIATION (If more than one, give % of time at each)
WHY WOULD YOU LIKE TO BE A MEMBER OF THE REGIONAL PHYSICIAN ADVISORY BOARD?
DESCRIBE YOUR SKILLS WHICH QUALIFY YOU FOR THIS POSITION.
WHAT DO YOU THINK IS THE MOST IMPORTANT ROLE OR ROLES OF THIS POSITION?

PLEASE RETURN THE COMPLETED APPLICATION AND CURRENT CURRICULUM VITAE TO:

Ohio Department of Public Safety
Division of EMS
P.O. Box 182073
Columbus, OH 43218-2073
(800) 233-0785 • Fax (614) 466-9461

Electronic Submission
Send to RPAB@dps.ohio.gov