



OHIO DEPARTMENT OF PUBLIC SAFETY  
DIVISION OF EMERGENCY MEDICAL SERVICES

**CHANGE IN LEVEL OF SERVICE  
MEDICAL TRANSPORTATION ORGANIZATION**

SERVICE NAME			SERVICE CODE
SERVICE ADDRESS			
CITY	STATE	COUNTY	ZIP CODE
CURRENT LEVEL OF SERVICE <input type="checkbox"/> BLS <input type="checkbox"/> INTERMEDIATE <input type="checkbox"/> ALS <input type="checkbox"/> MoICU			
PROJECTED LEVEL OF SERVICE <input type="checkbox"/> BLS <input type="checkbox"/> INTERMEDIATE <input type="checkbox"/> ALS <input type="checkbox"/> MoICU			
PROJECTED EFFECTIVE DATE			
CONTACT PERSON		CONTACT PHONE	

**OTHER REQUIREMENTS**

Check or Money Order in the amount of \$100.00 payable to Ohio Treasurer of State for Vehicle Notification Report and fees for required inspection(s) (if applicable).

**Upon receipt of information and successful completion of inspection, Emergency Medical Services will issue a new certificate indicating the new Level of Service. NOTE: Expiration date for the license will not change.**

**CERTIFICATION**

As the Owner, Operator, Chief, and / or Executive Officer of the Medical Transportation organization named in this application, I do hereby certify that all information provided is accurate and complete.

SIGNATURE OF OWNER / OPERATOR / CHIEF / EXECUTIVE OFFICER <b>X</b>	DATE
---	------

**Send to:**

Ohio Department of Public Safety  
Division of Emergency Medical Services  
1970 West Broad Street  
P.O. Box 182073  
Columbus, OH 43218-2073

Phone: (800) 233-0785      Fax: (614) 466-9461

**FOR STATE USE ONLY:**

INSPECTOR ASSIGNED: \_\_\_\_\_

DATE INSPECTOR NOTIFIED: \_\_\_\_\_

DATE CERTIFICATE MAILED: \_\_\_\_\_