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		
☐ MD ☐ DO	OHIO PHYSICIAN LICENSE NUMBER:		EXPIRATION DATE		

MEDICAL SPECIALTY *(Check all that apply)*

☐ Emergency Medicine ☐ Trauma ☐ Family Practice ☐ Surgery
☐ Pediatrics ☐ Internal Medicine ☐ 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?		

I attest that all of the information provided on this application is true and accurate to the best of my knowledge. I hereby give permission for the Ohio Department of Public Safety, Division of EMS to verify any of the information supplied. I understand that any false or misleading information may be grounds, as determined by the State Board of Emergency Medical, Fire, and Transportation Services (EMFTS Board), for denial of appointment to or removal from the Regional Physician Advisory Board.

APPLICANT'S SIGNATURE	DATE
X	

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