



OHIO DEPARTMENT OF PUBLIC SAFETY  
DIVISION OF EMERGENCY MEDICAL SERVICES

**CHANGE OF ADDRESS**

This information may also be updated online at <https://www.dps.ohio.gov/certrenewal/main.aspx>

All information shall be included. Incomplete applications **WILL NOT** be processed.

*(Please print legibly and use black or blue ink.)*

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

By submitting this form I attest that I am the individual named above and I authorize the Division of EMS to make this change to my record.

PRINTED NAME	SIGNATURE <b>X</b>	DATE
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**Please Mail Completed Forms To:**

OHIO DEPARTMENT OF PUBLIC SAFETY  
**DIVISION OF EMERGENCY MEDICAL SERVICES**  
1970 West Broad St., P.O. Box 182073  
Columbus, OH 43218-2073  
or  
Fax to: (614) 466-9461  
or  
E-mail to: [ems-firecertifications@dps.state.oh.us](mailto:ems-firecertifications@dps.state.oh.us)