



OHIO DEPARTMENT OF PUBLIC SAFETY
EMERGENCY MEDICAL SERVICES

**APPLICATION FOR GRANDFATHERED FIREFIGHTER
CERTIFICATE IN LIEU OF COMPLETION**

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

LAST NAME		FIRST NAME		MI
STREET ADDRESS				
CITY			STATE	ZIP CODE
COUNTY OF RESIDENCE	HOME PHONE NUMBER	WORK PHONE NUMBER	FAX NUMBER	
SOCIAL SECURITY NUMBER	Disclosure of social security number is mandatory pursuant to R.C. 3123.50 in furtherance of licensing provision and any other state or federal requirements		DATE OF BIRTH	E-MAIL ADDRESS
EMPLOYING FIRE DEPARTMENT		PRIMARY DEPARTMENT		
DEPARTMENT ADDRESS			DEPARTMENT PHONE NUMBER	
CITY		STATE	ZIP CODE	COUNTY
POSITION				DATE OF APPOINTMENT
STATUS <input type="checkbox"/> FULL TIME PAID <input type="checkbox"/> VOLUNTEER				

Attach proof that demonstrates you were a member of a Volunteer Fire Department prior to July 2, 1979 or a Paid Full Time Firefighter prior to July 2, 1970.

I attest that the information in this application is true and correct to the best of my knowledge. I hereby give permission to the Ohio Department of Public Safety, Division of Emergency Medical Services to verify any and all information.

APPLICANT SIGNATURE X	DATE
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Return to:

**OHIO DEPARTMENT OF PUBLIC SAFETY
EMERGENCY MEDICAL SERVICES**
P.O. Box 182073
Columbus, OH 43218-2073
(800) 233-0785 • (614) 466-9447 • Fax (614) 466-9461