



DATE	DOCUMENT ID	DESCRIPTION	FILING	EXPED	CERT	COPY
04/22/2025	202511203224	TRADE NAME REGISTRATION (RNO)	39.00	0.00	0.00	0.00

**Receipt**

This is not a bill. Please do not remit payment.

NATIONAL SERVICE INFORMATION, INC.  
145 BAKER STREET  
MARION, OH 43302

**STATE OF OHIO  
CERTIFICATE**

**Ohio Secretary of State, Frank LaRose  
5396589**

It is hereby certified that the Secretary of State of Ohio has custody of the business records for  
**CENTRAL OHIO TRAUMA SYSTEM**

and, that said business records show the filing and recording of:

Document(s)

**TRADE NAME REGISTRATION**

Effective Date: 04/22/2025

Document No(s):

**202511203224**



United States of America  
State of Ohio  
Office of the Secretary of State

Witness my hand and the seal of the  
Secretary of State at Columbus, Ohio this  
22nd day of April, A.D. 2025.

**Ohio Secretary of State**

Form 534A Prescribed by:

Date Electronically Filed: 4/22/2025

Toll Free: 877.767.3453 | Central Ohio: 614.466.3910

[OhioSoS.gov](http://OhioSoS.gov) | [business@OhioSoS.gov](mailto:business@OhioSoS.gov)

File online or for more information: [OhioBusinessCentral.gov](http://OhioBusinessCentral.gov)



## Name Registration

**Filing Fee: \$39**

**Form Must Be Typed**

**CHECK ONLY ONE (1) Box**

<input checked="" type="checkbox"/> Trade Name (167-RNO)	Date of first use: <input type="text" value="10/1/1999"/> MM/DD/YYYY	<input type="checkbox"/> Fictitious Name (169-NFO)
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<input type="text" value="Central Ohio Trauma System"/> Name being Registered or Reported
<input type="text" value="COTS"/> Name of the Registrant

**Note: If the registrant is a partnership, please provide the name of the partnership. Individual partner names are not permitted but are required on page 2 of the form.**

Registrant's Entity Number (if registered with Ohio Secretary of State):

**All registrants must complete the information in this section**

The general nature of business conducted by the registrant:

COTS is operated exclusively for charitable educational and scientific purposes and offers education, training and evaluation services to health care providers throughout Ohio to improve the efficiency, quality and performance of emergency medical services, trauma care services and emergency preparedness activities.

Business address:

Mailing Address

City

State

ZIP Code

**Complete the information in this section if registrant is a partnership NOT registered in Ohio pursuant to ORC 1776, if partnership is registered, provide registration number on page one.**

Provide the name and address of at least one general partner:

Name

Address







NOTE: Pursuant to OAG 89-081, if a general partner is a foreign corporation/limited liability company, it must be licensed to transact business in Ohio; if a general partner is a foreign corporation/limited liability company licensed in Ohio under an assumed name, please provide the assumed name and the name as registered in its jurisdiction of formation.

By signing and submitting this form to the Ohio Secretary of State, the undersigned hereby certifies that he or she has the requisite authority to execute this document.

**Required**

Application must be signed by the registrant or an authorized representative.

Signature

If authorized representative is an individual, then they must sign in the "signature" box and print their name in the "Print Name" box.

By (if applicable)

Print Name

If authorized representative is a business entity, not an individual, then please print the business name in the "signature" box, an authorized representative of the business entity must sign in the "By" box and print their name in the "Print Name" box.