TEXAS DEPARTMENT OF STATE HEALTH SERVICES
EMS EDUCATION PROGRAM

NOTIFICATION / CHANGE FORM

Revised 20150924

Submit this form with the appropriate coversheet and required documents to EMS Education in Austin.
See coversheet for mailing details.

For assistance with this form, contact EMSEducation@dshs.texas.gov or (512) 834-6704.

Education Program Information

Name of Legal Entity:			Education Program Number:
Entity Assumed / Operating Name (dba):			
Contact Phone Number:		Contact Email:	

☐ **Change in Program Ownership**

New Name of Owner		Effective Date:	
Owner Mailing Address:			
City, State, Zip		County:	
Reason for change:			
Required Documents:	1. Updated Self-Study (SD Card or USB Flash Drive)		

☐ **Change in Program Sponsorship**

New Program Sponsor:		Effective Date:	
Program Sponsor Mailing Address:			
City, State, Zip		County:	
Reason for change:			
Required Documents:	1. Updated Self-Study (SD Card or USB Flash Drive)		

☐ **Upgrade Level of Program**

Desired Effective Date:	
Courses being taught:	☐ ECA ☐ EMT-B ☐ AEMT ☐ Paramedic
Reason for Change:	
Required Documents:	1. Updated Self-Study (SD Card or USB Flash Drive) 2. Equipment List (SD Card or USB Flash Drive) 3. Copy of CoAEMSP Letter of Review (only if upgrading to paramedic level courses)

☐ **Downgrade Level of Program**

Desired Effective Date:	
Courses being taught:	☐ ECA ☐ EMT-B ☐ AEMT ☐ Paramedic
Reason for Change:	
Required Documents:	1. Updated Self-Study (SD Card or USB Flash Drive) 2. Equipment List (SD Card or USB Flash Drive)

☐ **Change in Program Address**

☐ Physical Address ☐ Mailing Address ☐ Records Location Address		Effective Date:	
Address:			
City, State, Zip		County:	
☐ Physical Address ☐ Mailing Address ☐ Records Location Address		Effective Date:	
Address:			
City, State, Zip		County:	
☐ Physical Address ☐ Mailing Address ☐ Records Location Address		Effective Date:	
Address:			
City, State, Zip		County:	
Required Documents:	1. Updated Self-Study (SD Card or USB Flash Drive)		

☐ **Classroom Site Change**

Location Name:		☐ Add	☐ Delete
Physical Address:			
City, State, Zip		County:	
Location Name:		☐ Add	☐ Delete
Physical Address:			
City, State, Zip		County:	
Location Name:		☐ Add	☐ Delete
Physical Address:			
City, State, Zip		County:	
Required Documents:	1. Equipment List and/or how equipment will be managed at the location. 2. Detailed Description and pictures of classroom 3. Classroom Agreement (if applicable)		

☐ **Field (EMS) Internship Site Change**

Field Site Name:		☐ Add	☐ Delete
Physical Address:			
City, State, Zip		County:	
Field Site Name:		☐ Add	☐ Delete
Physical Address:			
City, State, Zip		County:	
Required Documents:	1. Field Internship Site Agreement		

☐ **Clinical (Hospital) Internship Site Change**

Clinical Site Name:		☐ Add	☐ Delete
Physical Address:			
City, State, Zip		County:	
Clinical Site Name:		☐ Add	☐ Delete
Physical Address:			
City, State, Zip		County:	
Required Documents:	1. Clinical Internship Site Agreement		

☐ **CAAHEP / CoAEMSP Status Change (or other national accrediting organization recognized by the department)**

Required Documents:	• Accreditation self-study (Sim Card or USB Flash Drive) • Accreditation letter or certificate • Correspondence or updates to or from the national accrediting organization that impact the programs status.

☐ **Program Director Change**

New Program Director's Name:				DSHS Certification #	
Mailing Address:					
City, State, Zip				County:	
Phone:		Fax:		Email:	
Reason for Change:					

☐ **Program/Principal Coordinator Change**

New Program Coordinator's Name:				DSHS Certification #	
Mailing Address:					
City, State, Zip				County:	
Phone:		Fax:		Email:	
Reason for Change:					

☐ **Medical Director Change (Address must differ from program address)**

Previous Medical Director Name:				Departure Date:	
New Medical Director Name:				Medical License #	
Mailing Address:					
City, State, Zip				County:	
Phone:		Fax:		Email:	
Reason for Change:					
Required Documents:	1. Medical Director Agreement / Contract				

Print Name of Medical Director	Signature of Medical Director	Date

Program Director and Coordinator Authorization

On behalf of the above named legal entity, to the Texas Department of State Health Services, I hereby affirm and declare that all information submitted on this form and attached supplemental documents are true and correct. It is understood that any false information given or misrepresentation made in this application or other requested documents may result in revocation or denial of program approval/license. I have read, understand, and agree to abide by Chapter 773 of the Texas Health and Safety Code and Title 25 of the Texas Administrative Code, Chapter 157.

Print Name of Program Director	Signature of Program Director	Date

Print Name of Program Coordinator	Signature of Program Coordinator	Date