



TEXAS DEPARTMENT OF STATE HEALTH SERVICES
 EMS EDUCATION PROGRAM
Application Form
 Revised 20150924

Submit this form with the appropriate coversheet, fee and attachments to EMS Compliance in Austin.
 See coversheet for mailing details.

For assistance with this form, contact the appropriate regional Department of State Health Services (DSHS) EMS staff.
 See <http://www.dshs.state.tx.us/emstraumasystems/EMSComplianceRegOfcList.pdf> for contact information.

Education Program Information

Application Type:	Initial Renewal	If Renewal, Education Program Number:		
Name of Legal Entity:				Federal Tax ID Number:
Entity Assumed / Operating Name (dba):				
Physical Address:				
City, State, Zip			County:	
Mailing Address:				
City, State, Zip			County:	
Phone Number:		Fax:		
Program Level:	Basic Program: Self Study Evaluation Fee: \$32 – Site Visit Fee: \$93– Total Fee \$125			
	Advanced Program: Self Study Evaluation Fee: \$62 – Site Visit Fee: \$255 – Total Fee \$317			
	Request Fee Exemption – nonrefundable fees may be waived if the program receives no remuneration for providing training. TAC §157.32(q)			
If Advanced, Basic Program Approval date:		Program Open to Public?	Yes No	
Anticipated number of courses per year:		Anticipated number of students per course:		
Anticipated date of first course:		Primary Operating County:		

Program Director Information

Director Name:				DSHS License Number (If applicable)
Mailing Address:				
City, State, Zip			County:	
Phone Number:		Fax:		
Email:				

PRIVACY NOTIFICATION

Publication #: F01-13067 - Electronic Publication #: EF01-13067 Page 1 of 2
 With a few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See <http://www.dshs.state.tx.us> for information on Privacy Notification. (Reference Government Code, Section 552.021, 552.023 and 559.004)

Program Sponsor

Sponsor Name:			
Mailing Address:			
City, State, Zip		County:	

Course Coordinator Information

Coordinator Name:			DSHS License Number (If applicable)
Mailing Address:			
City, State, Zip		County:	
Phone Number:		Fax:	
Email:			

Medical Director Information (Address must differ from program address)

Medical Director Name:			Medical License Num.
Mailing Address:			
City, State, Zip		County:	
Phone Number:		Fax:	
Email:			
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

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