



**Texas Department of State Health Services
Professional Licensing and Certification Unit
Sanitarian Registration Program**
Mail Code 2003, P.O. Box 149347
Austin, Texas 78714-9347
www.dshs.state.tx.us/sanitarian
(512) 834-4517

Budget: ZZ103
Fund: 151

Application for Registration as a Sanitarian

I am applying for registration as (check only one):

- Professional Sanitarian (2 Year Term) - \$153 Fee
- Sanitarian in Training (2 Year Term) - \$138 Fee
- Upgrade to Professional Sanitarian - \$95 Fee

Note: An additional \$50 examination fee will be payable to "Pearson VUE" after application approval has been received.

I. Personal Information (Please Type or Print)

1. Name:			
	Last	First	Middle
2. Social Security Number:		3. Date of Birth:	
<small>(Disclosure of a social security number by an applicant is mandatory under Family Code, Section 231.302 and the Health Insurance Portability and Accountability Act of 1996, Section 221. Social Security numbers are confidential and will be used for identification and reporting purposes required by law.)</small>			
4. Address:			
	Street	City	State
		County	Zip Code
5. Telephone (Home):		Telephone (Work):	

II. Employer

6. Name:	
Address:	
	Street
	City
	County
	State
	Zip Code
Telephone:	

PRIVACY NOTIFICATION

With 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 more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)

III. Education

7. Please submit an official transcript of your college, university, and/or graduate record which verifies that degree and science requirements have been met. (Transcript must be original). List additional universities on a separate sheet.

College/University	Location	Science Hrs. Completed	Did you graduate?	Conferred Degrees/Yr.	Major
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

IV. General Information

8. Are you registered (or licensed) as a professional sanitarian in any other state or country? Yes No
Where? _____ Date of registration _____ Certificate/Lic. Number: _____
Are you currently certified by NEHA as an REHS/RS Yes No *If yes, please attach proof.*

Have you ever had your certificate or license to engage in sanitation or any other profession revoked, in this state or elsewhere? Yes No
If your answer is "Yes". Please explain in detail on an attached sheet the circumstances of the revocation.

9. Have you ever been convicted of a felony or a misdemeanor? Yes No If YES, provide:

Charge: _____

If conviction was set aside, give date and explain using additional pages if necessary: _____

(Discovery of criminal conviction information not disclosed may result in denial of your registration and disclosure of discovered information to other licensing boards/programs.)

10. If you are a Texas resident, how long immediately prior to this date? _____

Note: Applicants for Sanitarian-In-Training should not fill out 11 and 12 unless applicable experience has been obtained.

V. Employment Record

11. Begin with present position and work back to your first position.

Name	Address	City	State	Zip Code	Telephone
a. _____	_____	_____	_____	_____	_____
b. _____	_____	_____	_____	_____	_____
c. _____	_____	_____	_____	_____	_____

Note: Attach a detailed summary of experience (Including Employment Dates) on a separate sheet of paper.

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VI. References

12. Give names of three persons, who are familiar with your work, and to whom DSHS may address inquiries, if necessary. If possible, at least one registered/licensed sanitarian should be listed.

Name	Address	City	State	Zip Code	Telephone
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a. _____

b. _____

c. _____

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VII.

**Registered Sanitarian
Professional Reference Form**

PHOTOCOPY IF ADDITIONAL COPIES ARE NEEDED

Be sure to use a separate form for each organization or institution where the experience was gained. Be sure to submit experience sufficient to document two years of experience.

Name of Applicant: _____

Address of Applicant: _____
(Street No. or Box) (City) (State) (Zip)

The person certifying to his/her knowledge of the experience of the individual above shall complete the information below:

I, _____, certify that I have employed _____
(Employer) (Applicant)
from _____ to _____ and that I know of my own knowledge that said person was employed as
follows (Month/Day/Year) (Month/Day/Year)
and that his/her regularly assigned duties included work as a sanitarian:

1. Name and Address of Employer: _____

2. Briefly describe job responsibilities: _____

3. Job Title: _____

4. Check type of establishment or office in which work is/was performed:
 City Employment County State Agency
 Other, Specify: _____

5. Total number of hours per week applicant worked in the above duties: _____

6. Other pertinent information: _____

On this _____ day of _____, 20____, in _____, _____
(City) (State)

I certify under penalty of perjury that the information submitted is true and correct.

STATE OF TEXAS () _____
COUNTY OF () **Signature of Employer**

Sworn to and subscribed before me this _____ day of _____, 20____.

Notary's Signature NOTARY SEAL

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VIII.

Sanitarian-In-Training Supervision Form

PHOTOCOPY IF ADDITIONAL COPIES ARE NEEDED

Be sure to use a separate form for each organization or institution where the experience was gained. Be sure to submit experience sufficient to document two years of experience.

Name of Applicant: _____

Address of Applicant: _____
(Street No. or Box) (City) (State) (Zip)

The person certifying to his/her knowledge of the experience of the individual above shall complete the information below:

I, _____, certify that I have employed _____
(Employer) (Applicant)
from _____ to _____ and that I know of my own knowledge that said person was employed as follows
(Month/Day/Year) (Month/Day/Year)
and that his/her regularly assigned duties included work as a sanitarian-in-training:

1. Name and Address of Employer: _____

2. Briefly describe job responsibilities: _____

3. Job Title: _____

4. Check type of establishment or office in which work is/was performed:
 City Employment County State Agency
 Other, specify: _____

5. Total number of hours per week applicant worked in the above duties: _____

6. Other pertinent information: _____

On this _____ day of _____, 20____, in _____,
(City) (State)

I certify under penalty of perjury that the information submitted is true and correct.

STATE OF TEXAS () _____
COUNTY OF () **Signature of Employer**

Sworn to and subscribed before me this _____ day of _____, 20____.

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Request for Disability Accommodation

If you have a disability requiring appropriate accommodations in taking the state examination, be sure to complete this form along with the application. **In addition, please attach a statement on letterhead stationery from a professional who is familiar with your disability.** This statement must describe the disability for which you require accommodation.

1. Do you have any disability-related needs that we should be made aware of in order to provide appropriate accommodations for the examination? If the answer is yes, please specify.

Disability

2. Have you had any prior accommodations for your disability in an examination setting? If you answer yes, specify the type of accommodation. Have a professional familiar with your disability complete this information, if needed.

Disability

Type of Test Accommodation

_____	_____
_____	_____
_____	_____

3. If you have NOT had prior accommodation for a test, what do you feel would aid you in taking the examination? If you cannot answer this question by yourself, have a professional who knows your disability and the type of accommodation you need help answer this question. This professional could be a physician, psychologist, rehabilitation counselor, or other professional.

Disability

Type of Test Accommodation

_____	_____
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Please sign and date the bottom of this form. Make sure the professional who helps you complete the form also signs and dates this form. **Be sure to submit a statement on letterhead stationery from a professional who is familiar with your disability.**

Signature (Applicant)

Date

Signature (Professional)

Date