Texas Department of State Health Services
Emergency Medical Services
EMS Provider/First Responder Organization
Licensing Fee Payment Submittal Form

For DSHS Use Only - ZZ100-160
Remit Date _____
Remit No. _____
Amount Pd. _____

SEND THIS FORM WITH MAILED FEE SUBMISSIONS

EMS PROVIDER APPLICANT ADDRESSING INFORMATION: When sending EMS Provider/FRO Licensing submissions **that contain a fee payment,** please send to the appropriate address:

General Mail (US Mail):	**Overnight/Express/Parcel:**
Texas Department of State Health Services (DSHS) **Cash Receipts Branch – MC 2003** **PO Box 149347** **Austin, Texas 78714-9347**	**Texas Department of State Health Services (DSHS)** **Cash Receipts Branch – MC 2003** **1100 West 49th St.** **Austin, Texas 78756-3101**

Payment Submitted by (if different than applicant):	
Name of EMS Provider or FRO applicant:	
Applicant's Assumed Name or DBA (if applicable):	
Mailing Address:	
City, State, Zip	
Payment Amount:	
Submission Date:	
Mark documents enclosed:	☐ **PROVIDER – INITIAL APPLICATION** ☐ **Application form** ☐ **Fee** _____ ☐ **Other** _____ ☐ **PROVIDER – RENEWAL LICENSE #** _____ ☐ **Application form** ☐ **All items listed on checklist** ☐ **Fee** _____ ☐ **Other** _____ ☐ **FRO INITIAL APPLICATION** ☐ **Application form** ☐ **Fee** _____ ☐ **Other** _____ ☐ **FRO RENEWAL LICENSE #** _____ ☐ **Application form** ☐ **All items listed on checklist** ☐ **Fee** _____ ☐ **Other** _____

INTERNAL DSHS DELIVERY:
EMS Certification
Moreton Building – MC 1876