



TEXAS DEPARTMENT OF STATE HEALTH SERVICES  
EMERGENCY MEDICAL SERVICES  
PROVIDER LICENSE DECLARATION FORM  
Revision Date: 08/01/2014

Submit the completed form to the appropriate address and with the appropriate cover sheet, posted at:  
<http://www.dshs.state.tx.us/emstraumasystems/provfro.shtm>:

TYPE OR PRINT IN BLACK INK

**Initial Application**                       **Renewal Application – License Number:** \_\_\_\_\_

<b>Section 1 – Name of Legal Entity Applying for License</b>	
Legal Entity Name:	

<b>Section 2 – Entity Assumed Name, if applicable. (Attach copies of all assumed name certificates)</b>
Assumed Name:

<b>Section 3 –Administrator of Record</b>				
Administrator Name:			EMS Certification/ID #:	
Mailing Address:				
City:	State:	Zip:	Email:	
Business Phone:		Business Fax:		
<input type="checkbox"/> A completed emergency medical service (EMS) Administrator of Record Form is included. <input type="checkbox"/> Exempt, no form required. I am an administrator for an emergency medical services provider that is directly operated by a governmental entity.				

<b>Section 4 –Medical Director</b>				
Medical Director Name:			TX License # :	
Mailing Address:				
City:	State:	Zip:	Email:	
Business Phone:		Business Fax:		

<b>Section 5 – Vehicle Authorizations</b> (List the number of vehicle authorizations requested at each level and total.)						
BLS:		ALS:		Rotor Wing:		<b>TOTAL NUMBER OF AUTHORIZATIONS</b>
BLS with ALS Capability:		ALS with MICU Capability:		Fixed Wing:		
BLS with MICU Capability:		MICU:		Specialty:		

Legal Entity Name: \_\_\_\_\_

<b>Section 6 – Information</b>		
<b>Entity Type:</b> <i>Check any that apply or explain.</i> <input type="checkbox"/> Governmental Entity <i>Type of Government Entity:</i> <input type="checkbox"/> City <input type="checkbox"/> County <input type="checkbox"/> Emergency Service District <input type="checkbox"/> Hospital District <input type="checkbox"/> _____ <input type="checkbox"/> Hospital <input type="checkbox"/> Private <input type="checkbox"/> _____	<b>Response Type:</b> <i>You must check only one.</i> <input type="checkbox"/> Emergency / 911 <input type="checkbox"/> Non-Emergency / Non-911 <input type="checkbox"/> Both	<b>Subscription:</b> <i>You must answer.</i>  Does your organization offer a subscription program? <input type="checkbox"/> Yes <input type="checkbox"/> No
	<b>Organization Tax Status:</b> <i>You must check only one.</i> <input type="checkbox"/> Governmental Entity <input type="checkbox"/> For Profit <input type="checkbox"/> Non-Profit 501c3 <input type="checkbox"/> _____	<b>EMS Personnel Status:</b> <i>You must check only one.</i> <input type="checkbox"/> Paid/Non-Volunteer <input type="checkbox"/> Mixed <input type="checkbox"/> Volunteer

<b>Section 7 - Letter of Credit:</b>
Attach a copy of a letter of credit issued by a federally insured bank or savings institution. An emergency medical services provider that is directly operated by a governmental entity is exempt from this section.
Institution Name: _____ Date of Letter: _____
Amount of required credit: (must choose one)
<input type="checkbox"/> a) Exempt - Governmental Entity. <input type="checkbox"/> d) Year 6 until year 8 after initial license: \$50,000.
<input type="checkbox"/> b) Year 1 until year 4 after initial license: \$100,000. <input type="checkbox"/> e) Year 8 until year 10 after initial license: \$25,000.
<input type="checkbox"/> c) Year 4 until year 6 after initial license: \$75,000. <input type="checkbox"/> f) In business more than ten years.

<b>Section 8 - Medicaid Provider Surety Bond</b>
This EMS organization is required to provide a surety bond as a condition of participation in the Medicaid program and as required by the Texas Health and Humans Services Commission. An EMS provider that is directly operated by a governmental entity is exempt from this section.
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Exempt (Governmental Entity)
If No please explain: _____
Bond Number: _____
Name of institution issuing bond and contact telephone number: _____

Legal Entity Name: \_\_\_\_\_

**Section 9 – Service Area**

Provide the City(s) and County(s) you plan to operate in. If you need more space Please provide all of the required information on a separate piece of paper. Additional Sheet(s) attached:

- 1. City: \_\_\_\_\_ County: \_\_\_\_\_
- 2. City: \_\_\_\_\_ County: \_\_\_\_\_
- 3. City: \_\_\_\_\_ County: \_\_\_\_\_
- 4. City: \_\_\_\_\_ County: \_\_\_\_\_
- 5. City: \_\_\_\_\_ County: \_\_\_\_\_
- 6. City: \_\_\_\_\_ County: \_\_\_\_\_

**Section 10 – Governmental Recognition**

List and attach recognition from governmental entities. This section does not apply to renewal of an emergency medical services provider license or a municipality, county, emergency services district, hospital, or emergency medical services volunteer provider organization in this state that applies for an emergency medical services provider license. If you need more space Please provide all of the required information on a separate piece of paper. Additional Sheet(s) attached:

- 1. City: \_\_\_\_\_ County: \_\_\_\_\_
- 2. City: \_\_\_\_\_ County: \_\_\_\_\_
- 3. City: \_\_\_\_\_ County: \_\_\_\_\_
- 4. City: \_\_\_\_\_ County: \_\_\_\_\_
- 5. City: \_\_\_\_\_ County: \_\_\_\_\_
- 6. City: \_\_\_\_\_ County: \_\_\_\_\_

**Section 11 – Addresses (Station locations will be listed on a separate form.)**

Headquarters/Primary Location Street Address:

Street address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

Records Location Street Address:  Same as headquarters

Street address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

Billing Office Street Address:  Same as headquarters

Street address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

Legal Entity Name: \_\_\_\_\_

Dispatch Location Street Address:  Same as headquarters

Street address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

**Section 12 –Ownership & Type of Legal Entity**

Complete the following and have this document notarized to indicate the type of legal entity and responsible persons.

- Government Entity  Sole Proprietorship  Partnership/General Partnership  Unincorporated Association of People
- Corporation  Limited Liability Company  Limited Partnership  Limited Liability Partnership
- Other (*must explain*) \_\_\_\_\_

Please complete this information for all officers, general partners and limited partners of the legal entity. Government Entities should complete this information for the chief elected official (i.e. city mayor or county judge) or appointed officials that are responsible for the entity (i.e. emergency service district or hospital district board members).

The Date of Birth's are required. (*Attach additional sheets if necessary.*) Additional Sheet(s) attached

Name \_\_\_\_\_

Date of Birth (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Title \_\_\_\_\_

Mailing address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name \_\_\_\_\_

Date of Birth (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Title \_\_\_\_\_

Mailing address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name \_\_\_\_\_

Date of Birth (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Title \_\_\_\_\_

Mailing address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name \_\_\_\_\_

Date of Birth (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Title \_\_\_\_\_

Mailing address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name \_\_\_\_\_

Date of Birth (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Title \_\_\_\_\_

Mailing address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name \_\_\_\_\_

Date of Birth (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Title \_\_\_\_\_

Mailing address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Legal Entity Name: \_\_\_\_\_

**Section 13- Medicare and/or Medicaid Eligibility**

The applicant, management team and medical director must not be excluded from participation in the Medicare and/or Medicaid program.

I certify that the applicant, management team and medical director are not excluded from participation in the Medicare and/or Medicaid program.

**Section 14 – Knowledge and Experience (After September 1, 2014)**

I certify that the applicant and/or management team are knowledgeable or have experience in the following: Have read the Texas Emergency Healthcare Act and the Department’s EMS rules, The emergency medical dispatch processes; The EMS medical control processes; The EMS billing processes; The quality improvement processes for EMS operations.

**Section 15 – Signature and Date**

On behalf of the above named legal entity, to the Texas Department of State Health Services. I hereby affirm and declare that I am authorized to make this declaration and that all information submitted on this form and any attached supplemental documents are true and correct. 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. I understand that it is a violation of Title 25 of the Texas Administrative Code Chapter 157 and the Texas Penal Code to submit a false statement to the Department. 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 license.

_____	
Signature of Owner, Applicant, Agent or Administrator	Date:
Print Name	Date

**Section 16 - Notary Statement**

**THE STATE OF TEXAS**

**COUNTY OF** \_\_\_\_\_

Before me, the undersigned authority, on this day personally appeared \_\_\_\_\_, known to me to be the person whose name is subscribed to the foregoing instrument and under oath, acknowledged to me that he/she signed the same for the purpose and consideration therein expressed.

Given under my hand and seal on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

(SEAL)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

My commission expires \_\_\_\_\_

**Privacy Notification:** With a few exceptions, you have the right to request and be informed about information the State of Texas collect 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 and 559.004)