



**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 \$75 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	County	State	Zip Code	
5. Telephone (Home): _____		Telephone (Work): _____			

II. Employer

6. Name: _____				
Address: _____				
Street				

City	County	State	Zip Code	
Telephone: _____				
Fax number: _____				

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)

DSHS Publication Number: F82-11543 Rev. 11/13

III. Education

7. Submit an official transcript from your college, university, and/or graduate record which verifies that degree and science requirements have been met. (Transcript(s) must be original). List additional universities on a separate sheet if necessary. **You must document 30 hours of coursework in basic or applied sciences on pages 2-4 of this packet. If you are applying for an Upgrade, you do NOT have to document your 30 hours or resubmit your transcripts.**

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

EDUCATIONAL REQUIREMENTS FOR EXAMINATION AND REGISTRATION

For new Sanitarian-in-Training and Sanitarian applicants only. **If you are applying for an Upgrade, you do not have to complete this section.** In the space provided below, please document the 30 semester hour (or its equivalent) coursework minimum requirement in basic or applied sciences that you completed at an accredited college or university. You are only required to complete a minimum of 30 hours in any of the following acceptable courses. *Your application must include official transcripts verifying completion of courses.* Dropped courses are not acceptable.

Course	Course title & number on transcript	Number of semester hours	Final Grade	Full title of course
Air Pollution				
Anatomy				
Animal Science				
Bacteriology				
Biochemistry				
Biology				
Biomedical Science				
Biophysics (no more than 6 semester hours or its equivalent)				
Biostatistics				
Botany				
Cell Physiology				
Chemical Engineering				
Chemistry				
Community Health				
Computer Science (no more than 6 semester hours or its equivalent)				
Dairy Science				
Ecology				

Course	Course title & number on transcript	Number of semester hours	Final Grade	Full title of course
Embryology (no more than 6 semester hours or its equivalent)				
Entomology				
Environmental Health				
Environmental Science				
Environmental Diseases				
Environmental Law				
Epidemiology				
Food Bacteriology				
Food Science				
Food Technology				
Genetics				
Geophysics				
Geology				
Hazardous Waste				
Histology				
Hydrogeology				
Hydrology				
Industrial Hygiene				
Infectious Diseases				
Limnology				
Mathematics (beyond algebra- no more than 6 semester hours or its equivalent)				
Courses taken in an accredited allopathic or osteopathic school of medicine (no more than six semester hours or its equivalent)				
Meteorology (no more than 6 semester hours or its equivalent)				
Microbiology				
Molecular Biology				
Occupational Health				
Occupational Safety				
Parasitology				

Course	Course title & number on transcript	Number of semester hours	Final Grade	Full title of course
Pathology				
Physics (no more than 6 semester hours or its equivalent)				
Physiology				
Plant Taxonomy				
Public Health				
Public Health Education (no more than 6 semester hours or its equivalent)				
Public Health Law				
Radiological Health				
Sanitary Engineering				
Soil Science				
Statistics (no more than 6 semester hours or its equivalent)				
Toxicology				
Vector Control				
Veterinary Medical Courses (no more than 6 semester hours or its equivalent)				
Veterinary Public Health				
Virology				
Wastewater Treatment				
Water Quality				
Zoology				

Courses not listed above may be submitted for consideration for acceptance by the department. Please list those courses in the space provided below. Courses considered not acceptable are anthropology; archaeology; astronomy; education; geography; government; history; kinesiology; languages; physical education; psychology; and sociology.

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IV. General Information (All applicants must complete this section.)

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, 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 YES, explain in detail on an attached sheet the circumstances of the revocation.

9. Have you ever been arrested, charged, or convicted of a felony or misdemeanor? ____ **Yes** ____ **No** If YES, provide:
Charge, Date, and Explanation. Additional court documents may be required. Discovery of criminal conviction information **not disclosed** may result in **denial** of your registration and disclosure of discovered information to other licensing boards/programs.
Charge/Date/Explanation: _____

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

10. If you are a Texas resident, how long have you been a resident? _____

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) and a job description on a separate sheet of paper.

VI. References

12. Give names, addresses, and phone numbers of three (3) 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. Attach a separate sheet if necessary.

a. _____

b. _____

c. _____



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PLEASE READ CAREFULLY

In making application to the Texas Department of State Health Services for registration as a sanitarian or a sanitarian-in-training, I have read, understood, and agree to comply with the Occupations Code, Chapter 1953, and the rules of the Texas Department of State Health Services relating to the Sanitarian Registration Program (Title 25, Texas Administrative Code, Chapter 140, Subchapter C). I also agree to complete all application requirements for the processing of my application.

I further understand that the fee submitted with this application is non-refundable and that the materials submitted for consideration become the property of the Department and are non-returnable. I am aware of the schedule of fees and understand that additional fees must be paid prior to registration.

I further agree that I shall return to the Department any registration upon the expiration and nonrenewal, revocation, or suspension of the registration.

The information which I have provided in this application is truthful and complete. I understand that providing false and misleading information on items which are material in determining my qualifications may result in the voiding of the application, or denial or the revocation of any registration issued.

Date

Signature of Applicant

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VII.

**REGISTERED SANITARIAN
PROFESSIONAL REFERENCE FORM**

PHOTOCOPY IF ADDITIONAL COPIES ARE NEEDED

Use a separate form for each organization or institution where the experience was gained. Be sure to submit experience sufficient to document two (2) years of experience (not less than 32 hours per week).

Name of Applicant: _____ Phone #: _____

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
(Month/Day/Year) (Month/Day/Year)
as followed 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

Use a separate form for each organization or institution where the experience is gained. As a Sanitarian-in-Training, you will need to document two (2) years of experience to upgrade to a sanitarian. Use this form if you have less than 2 years of experience.

Name of Applicant: _____ Phone #: _____

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 am the employer of _____
(Employer's Name) (Applicant's Name)
from _____ to _____, and I know of my own knowledge that the said
(Month/Day/Year) (Month/Day/Year)
person was/is employed as follows and that his/her regularly assigned duties include/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____.

Notary's Signature

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PRIVACY NOTIFICATION

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IX.

Sanitarian-In-Training Upgrade to Registered Sanitarian Form

- Upgrade to Professional Sanitarian - \$95 Fee

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. You must document two (2) years of experience (not less than 32 hours per week).

Name of Applicant: _____ Phone #: _____

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
 (Month/Day/Year) (Month/Day/Year)
 followed 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_____.

Notary's Signature

NOTARY SEAL

PRIVACY NOTIFICATION

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Budget: ZZ103

Fund: 151

Name: _____

Request for Disability Accommodation for Sanitarian Examination

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, 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? YES NO If the answer is YES, please specify.

Disability: _____

2. Have you had any prior accommodations for your disability in an examination setting? YES NO 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
_____	_____
_____	_____

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 _____