



**TEXAS DEPARTMENT OF
STATE HEALTH SERVICES
FIRST RESPONDER ORGANIZATION
ADMINISTRATOR INFORMATION FORM**

Rev 20141016

Submit this form to:
EMS Certification – MC 1876, PO Box 149347, Austin, TX 78714-9347
For assistance you may contact EMS Certification at 512-834-6734 or contact the appropriate regional DSHS EMS staff.
See <http://www.dshs.state.tx.us/emstraumasystems/EMSComplianceRegOfcList.pdf> for contact information

Section 1 – First Responder Organization Name and Administrator Information

Name of Legal Entity:				Provider/FRO ID#	
Entity Assumed or Operating Name:					
Administrator Name:		Certification Level: (if applicable)		ID #: (if applicable)	
Mailing Address:	Physical Address:				
City, State, Zip:	City, State, Zip:				
Home/Cell Phone:	()	Business Phone:	()		
Email:		Business Fax:	()		

Section 2 – Owner and Administrator 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 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 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.

Printed name of Person with signature authority	Signature of Owner/Person with signature authority	Date
Printed Name of Administrator	Signature of Administrator	Date

Section 3 – 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)

	Print Name	Signature