Regulatory Licensing Unit
EMS Certification & Licensing Group

EMS Certificate/Wallet Card Replacement Form

To request a duplicate EMS wallet card, submit completed form with check or money order payable to Texas Dept of State Health Services. Mail to:
Cash Receipts Branch, MC 2003
P.O. Box 149347
Austin, Texas 78714-9347

Section 1 – Personnel Data **TYPE OR PRINT IN BLACK INK**

Requesting duplicate wallet card for the following level: ☐ **ECA** ☐ **EMT** ☐ **EMT-I** ☐ **EMT-P** ☐ **Lic-P** ☐ **Coordinator** ☐ **EMS Instructor** ☐ **EMS Information Operator Instructor**

☐ **Enclosing $10** ☐ **Exempt from fee – Complete Section 2 - Volunteer Sign-Off below.**

_____ _____
Print Last Name **First Name** **Middle Name** **Social Security number***

_____
Address: Street, Apt Number or PO Box **City** **State** **Zip**

(____)_____ (____)_____ _____
Home Phone (area code) **Business Phone (area code)** **Date of Birth (MM/DD/YY)**

Are you requesting a copy of your ☐ Wallet Card, ☐ Wall Certificate, or ☐ Both

Section 2 - Volunteer Sign-Off – Complete if applicable

If you are claiming fee exempt status, this section should be completed by approved EMS Provider or FRO administrator.
This candidate is exempt from the payment of fees because he/she actively provides emergency medical care for our organization, and does not receive compensation* for providing these services. Additionally, to the best of my knowledge, this candidate does not provide emergency care for any organization, in return for compensation***, other than reimbursement as described below. I have explained to the candidate that if during the certification period, they begin to receive compensation*** for providing emergency medical services from any organization, the exemption is inapplicable and they are required to send a prorated fee to the department.**

_____ _____
Signature of provider or FRO administrator **Print signed name**

***Compensation does not include reimbursement for actual expenses for medical supplies, gasoline, clothing, meals and insurance incurred while volunteering.

Provider or FRO name: **City:**

DSHS license or registration number: **Phone:**

Section 3 – Signature and Date

I swear or affirm that all information in this application is true and correct. I further certify by signature hereon, that I am authorized to execute this document. I am not delinquent in the payment of any child support owed under Chapter 232, Family Code. I further certify that I have read and understood Chapter 773 of the Health and Safety Code, the applicable provisions of 25 TAC, Chapter 157, and agree to abide by them.

Signature of Applicant: _____ **Date:** _____

PRIVACY NOTIFICATION: With few exceptions, you have the right to request and be informed about information that 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 522.021, 522.023 and 559.004)

* Disclosure of your social security number is mandatory under Family Code, Chapter 232