



Regulatory Licensing Unit
EMS Certification & Licensing Group
EMS Instructor Retest Application
 Department of State Health Services
 Cash Receipts Branch, MC 2003
 P.O. Box 149347
 Austin, TX. 78714-9347

For DSHS Use Only ZZ100-160 Receipt # _____ Date _____
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See Privacy Notice below. All information given on this application is considered public record, with the exception of social security number*.

APPLICATION SUBMISSION:

- Expect application processing to take approximately 4-6 weeks.
- Check your certification status at:
<http://www.dshs.state.tx.us/emstraumasystems/NewCert.shtm>
- Submit application and fee, if not exempt, to address listed above

FEE: Make check or money order payable to the Texas Dept of State Health Services

- \$30.00 retest fee
- I am exempt from fee because I meet the department's definition of exempt volunteer personnel.

*If claiming exempt status, you must complete Volunteer

TESTING INSTRUCTIONS:

- Schedule exam AFTER application & processing at: www.nremt.org

TYPE OR PRINT IN BLACK INK

Print Last Name	First Name	Middle Name	Social Security number*

Mailing Address: Street, Apt Number or PO Box		City	State Zip
_____		_____	_____
Home Phone (area code)	Business Phone (area code)	Date of Birth (MM/DD/YY)	
_____	_____	_____	
*Disclosure of your social security number is mandatory under Family Code, Chapter 232			
Are you associated with a DSHS licensed or registered EMS Provider or 1st Responder? <input type="checkbox"/> Yes or <input type="checkbox"/> No			
If yes, are you: <input type="checkbox"/> Salaried – Employment date: _____ <input type="checkbox"/> Volunteer			
<u>If you are claiming fee exempt status, this section should be completed by approved EMS Provider or FRO Administrator.</u>			
This applicant is exempt from the payment of fees because he/she actively provides EMS instruction for our organization, and does not receive compensation* for providing these services. Additionally, to the best of my knowledge, this applicant does not provide instruction for any organization, in return for compensation, other than reimbursement as described below. I have explained to the applicant that if during the certification period, he/she begins to receive compensation for providing EMS instruction from any organization, the exemption is nullified and he/she must 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 FRO Name		City	
_____		_____	
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)