TEXAS Health and Human Services | Texas Department of State Health Services

# EMERGENCY MEDICAL SERVICES PROVIDER LICENSE LICENSE REPLACEMENT REQUEST REVISED: 09/07/2017

| Submit this completed form along with payment and appropriate cover sheet. Cover Sheets contain address info and can be found at www.dshs.state.tx.us/emstraumasystems/provfro.shtm. | **For DSHS Use Only - ZZ100-160** Remit Date_____ Remit No._____ Amount Pd._____ |
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**TYPE OR PRINT IN BLACK INK**

## Section 1 - Provider Data

Requesting duplicate of the following: ☐ EMS Provider License Certificate ☐ Vehicle Authorization ☐ Both

Number & Level of Authorizations being requested _____

☐ Enclosing $10.00 Fee, per item being requested.

☐ Exempt from Fee - Complete Section 2 / Volunteer Provider

*This form is to be used to replace a lost or destroyed provider license or vehicle authorization only.*

Name of Legal Entity Provider License #

Legal Entity Assumed Name

Mailing Address City State Zip

(Area Code) Business Phone (Area Code) Business Fax Email address

## Section 2 – Fee Exempt Status

On behalf of the above named legal entity, to the Texas Department of State Health Services, I hereby affirm and declare that the following provisions of 25 TAC, Chapter 157: 1) provides emergency prehospital care, 2) operates with at least 75% volunteer personnel, 3) have no more than five full-time paid staff or the equivalent and 4) the firm is recognized as a Section 501 (c)(3) nonprofit corporation by the Internal Revenue Service.

Volunteer /Fee Exempt Status: ☐ YES ☐ NO

If fee exempt, Fax: 512-834-6714 or Email to emsproviderfro@dshs.texas.gov

## Section 3 - Signature and Date

On behalf of the above named legal entity, I hereby affirm and declare I am authorized to make this Emergency Medical Services Provider application and/or declaration and all information submitted on this form and any supplemental documents are true and correct. I attest and understand the legal entity and I are accountable and responsible for the accuracy of all answers and statements on this form. I attest the legal entity listed on this form meets all requirements for the type of license requested. Further, I understand it is a Class A misdemeanor violation of Texas Penal Code Sec. 37.10 to submit a false statement to a governmental agency. I have read and understand Health and Safety Code Chapter 773 and Texas Administrative Code Title 25, Chapter 157, and agree to adhere to those statutes rules, and all other applicable statutes and rules.

Signature of Administrator of Record Printed Name of Administrator of Record

Date: _____ Phone: _____

**PRIVACY NOTIFICATION** With a 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 information on Privacy Notification. (Reference Government Code, Section 552.021, 552.023 and 559.004)