



**TEXAS DEPARTMENT OF STATE HEALTH SERVICES  
EMS CONTINUING EDUCATION PROGRAM  
NOTIFICATION / CHANGE FORM  
20150924**

**Submit this form with the appropriate supplemental documentation by fax or email to EMS Compliance.**

Fax: 512-821-4510      Email: [emscompliance\\_central@dshs.state.tx.us](mailto:emscompliance_central@dshs.state.tx.us)

For assistance with this form, contact the appropriate regional Department of State Health Services (DSHS) EMS staff.  
See <http://www.dshs.state.tx.us/emstraumasystems/EMSComplianceRegOfcList.pdf> for contact information

**Education Program Information**

Name of Legal Entity:			Continuing Education Program Number:
Entity Assumed / Operating Name (dba):			
Contact Phone Number:		Contact Email:	

**Change in Program Address**

<input type="checkbox"/> Physical Address	<input type="checkbox"/> Mailing Address	<input type="checkbox"/> Records Location Address	Effective Date:	
Address:				
City, State, Zip			County:	
<input type="checkbox"/> Physical Address	<input type="checkbox"/> Mailing Address	<input type="checkbox"/> Records Location Address	Effective Date:	
Address:				
City, State, Zip			County:	
<input type="checkbox"/> Physical Address	<input type="checkbox"/> Mailing Address	<input type="checkbox"/> Records Location Address	Effective Date:	
Address:				
City, State, Zip			County:	

**Program Director**

New Program Director's Name:		DSHS Certification #	
Mailing Address:			
City, State, Zip			County:
Phone:		Fax:	Email:
Reason for Change:			

**PRIVACY NOTIFICATION**

Publication #: F01-13067 - Electronic Publication #: EF01-13067

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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)

Other (Explain below)

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**Program Director Authorization**

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 program approval/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.

Print Name of Program Director	Signature of Program Director	Date

**PRIVACY NOTIFICATION**

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