



**Texas Department of State Health Services
Emergency Medical Services
EMS Provider/First Responder Organization
Licensing Fee Payment Submittal Form**



**SEND THIS FORM WITH
MAILED FEE SUBMISSIONS**

For DSHS Use Only - ZZ100-160

Remit Date _____

Remit No. _____

Amount Pd. _____

EMS PROVIDER APPLICANT ADDRESSING INFORMATION: When sending EMS Provider/FRO Licensing submissions that contain a fee payment, please send to the appropriate address:

<p><u>General Mail (US Mail):</u></p> <p>Texas Department of State Health Services (DSHS) Cash Receipts Branch – MC 2003 PO Box 149347 Austin, Texas 78714-9347</p>	<p><u>Overnight/Express/Parcel:</u></p> <p>Texas Department of State Health Services (DSHS) Cash Receipts Branch – MC 2003 1100 West 49th St. Austin, Texas 78756-3101</p>
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Payment Submitted by (if different than applicant):	
Name of EMS Provider or FRO applicant:	
Applicant's Assumed Name or DBA (if applicable):	
Mailing Address:	
City, State, Zip	
Payment Amount:	
Submission Date:	
Mark documents enclosed:	<input type="checkbox"/> PROVIDER – INITIAL APPLICATION
	<input type="checkbox"/> Application form
	<input type="checkbox"/> Fee _____ <input type="checkbox"/> Other _____
	<input type="checkbox"/> PROVIDER – RENEWAL LICENSE # _____
	<input type="checkbox"/> Application form <input type="checkbox"/> All items listed on checklist
	<input type="checkbox"/> Fee _____ <input type="checkbox"/> Other _____
	<input type="checkbox"/> FRO INITIAL APPLICATION
	<input type="checkbox"/> Application form
	<input type="checkbox"/> Fee _____ <input type="checkbox"/> Other _____
	<input type="checkbox"/> FRO RENEWAL LICENSE # _____
	<input type="checkbox"/> Application form <input type="checkbox"/> All items listed on checklist
	<input type="checkbox"/> Fee _____ <input type="checkbox"/> Other _____

**INTERNAL DSHS DELIVERY:
EMS Certification
Exchange Building – MC 2835**

