



EMS Certificate/Wallet Card
Replacement Form

Texas Department of State
Health Services

To request a duplicate EMS wallet card, submit completed form with check or money order payable to Texas Dept of State Health
Services and mail to: Texas Dept of State Health Services, 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-P Lic-P
EMS Instructor EMS Information Operator Instructor Coordinator

Fee Are you requesting a copy of your

\* If exempt, complete Section 2 - Volunteer Sign-Off below.

Last Name First Name Middle Name Social Security number\*

Address: 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

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 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)