Texas Department of State Health Services
Professional Licensing and Certification Unit
Sanitarian Registration Program
Mail Code 2003, P.O. Box 149347
Austin, Texas 78714-9347
www.dshs.state.tx.us/sanitarian
(512) 834-4517

Budget: ZZ103
Fund: 151

APPLICATION FOR REGISTRATION AS A SANITARIAN

I am applying for registration as (check only one):

[ ] Professional Sanitarian (2 Year Term) - $153 Fee
[ ] Sanitarian-in-Training (2 Year Term) - $138 Fee
[ ] Upgrade to Professional Sanitarian - $95 Fee

Note: An additional $75 examination fee will be payable to "Pearson VUE" after application approval has been received.

I. Personal Information (Please Type or Print)

1. Name:_____
Last First Middle

2. Social Security Number: _____ 3. Date of Birth: _____
(Disclosure of a social security number by an applicant is mandatory under Family Code, Section 231.302 and the Health Insurance Portability and Accountability Act of 1996, Section 221. Social Security numbers are confidential and will be used for identification and reporting purposes required by law.)

4. Address:_____
Street City County State Zip Code

5. Telephone (Home): _____ Telephone (Work): _____

II. Employer

6. Name: _____

Address: _____
Street City County State Zip Code

Telephone: _____

PRIVACY NOTIFICATION
With 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 more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)

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III. Education

7. Please submit an official transcript of your college, university, and/or graduate record which verifies that degree and science requirements have been met. (Transcript must be original). List additional universities on a separate sheet. ***You must document 30 hours of coursework in basic or applied sciences on pages 2-4 of this packet.***

College/University	Location	Science Hrs. Completed	Did you graduate?	Conferred Degrees/Yr.	Major

EDUCATIONAL REQUIREMENTS FOR EXAMINATION AND REGISTRATION

In the space provided below, please document the 30 semester hour (or its equivalent) coursework minimum requirement in basic or applied sciences that you completed at an accredited college or university. You are only required to complete a minimum of 30 hours in any of the following acceptable courses. *Your application must include official transcripts verifying completion of courses.* If you did not complete a specified course, leave that section blank.

Course	**Course title & number on transcript**	**Number of semester hours**	**Full title of course**
Air Pollution			
Anatomy			
Animal Science			
Bacteriology			
Biochemistry			
Biology			
Biomedical Science			
Biophysics (no more than 6 semester hours or its equivalent)			
Biostatistics			
Botany			
Cell Physiology			
Chemical Engineering			
Chemistry			
Community Health			
Computer Science (no more than 6 semester hours or its equivalent)			
Dairy Science			
Ecology			

Course	Course title & number on transcript	Number of semester hours	Full title of course
Embryology (no more than 6 semester hours or its equivalent)			
Entomology			
Environmental Health			
Environmental Science			
Environmental Diseases			
Environmental Law			
Epidemiology			
Food Bacteriology			
Food Science			
Food Technology			
Genetics			
Geophysics			
Geology			
Hazardous Waste			
Histology			
Hydrogeology			
Hydrology			
Industrial Hygiene			
Infectious Diseases			
Limnology			
Mathematics (beyond algebra- no more than 6 semester hours or its equivalent)			
Courses taken in an accredited allopathic or osteopathic school of medicine (no more than six semester hours or its equivalent)			
Meteorology (no more than 6 semester hours or its equivalent)			
Microbiology			
Molecular Biology			
Occupational Health			
Occupational Safety			
Parasitology			
Pathology			
Physics (no more than 6 semester hours or its equivalent)			

Course	Course title & number on transcript	Number of semester hours	Full title of course
Physiology			
Plant Taxonomy			
Public Health			
Public Health Education (no more than 6 semester hours or its equivalent)			
Public Health Law			
Radiological Health			
Sanitary Engineering			
Soil Science			
Statistics (no more than 6 semester hours or its equivalent)			
Toxicology			
Vector Control			
Veterinary Medical Courses (no more than 6 semester hours or its equivalent)			
Veterinary Public Health			
Virology			
Wastewater Treatment			
Water Quality			
Zoology			

Courses not listed above may be submitted for consideration for acceptance by the department. Please list those courses in the space provided below. Courses considered not acceptable are anthropology; archaeology; astronomy; education; geography; government; history; kinesiology; languages; physical education; psychology; and sociology.

_____

_____

_____

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IV. General Information

8. Are you registered (or licensed) as a professional sanitarian in any other state or country? _____ **Yes** _____ **No**

Where? _____ Date of registration _____ Certificate/Lic. Number: _____

Are you currently certified by NEHA as an REHS/RS ___ **Yes** ___ **No** *If YES, attach proof.*

Have you ever had your certificate or license to engage in sanitation or any other profession revoked, in this state or elsewhere? _____ **Yes** _____ **No**
If YES, explain in detail on an attached sheet the circumstances of the revocation.

9. Have you ever been convicted of a felony or a misdemeanor? ___ **Yes** ___ **No** If YES, provide: Charge, Date, and Explanation. Additional court documents may be required. Discovery of criminal conviction information **not disclosed** may result in **denial** of your registration and disclosure of discovered information to other licensing boards/programs.

Charge/Date/Explanation:_____

_____

_____

If conviction was set aside, give date and explain using additional pages if necessary: _____

_____

10. If you are a Texas resident, how long immediately prior to this date? _____

V. Employment Record

11. Begin with present position and work back to your first position.

	Name	Address	City	State	Zip Code	Telephone
a.						
b.						
c.						

Note: Attach a detailed summary of experience (Including Employment Dates) on a separate sheet of paper.

VI. References

12. Give names of three persons, who are familiar with your work, and to whom DSHS may address inquiries, if necessary. If possible, at least one registered/licensed sanitarian should be listed.

	Name	Address	City	State	Zip Code	Telephone
a.						
b.						
c.						

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PLEASE READ CAREFULLY

In making application to the Texas Department of State Health Services for registration as a sanitarian or a sanitarian-in-training, I have read, understood, and agree to comply with the Occupations Code, Chapter 1953, and the rules of the Texas Department of State Health Services relating to the Sanitarian Registration Program (Title 25, Texas Administrative Code, Chapter 140, Subchapter C). I also agree to complete all application requirements for the processing of my application.

I further understand that the fee submitted with this application is non-refundable and that the materials submitted for consideration become the property of the Department and are non-returnable. I am aware of the schedule of fees and understand that additional fees must be paid prior to registration.

I further agree that I shall return to the Department any registration upon the expiration and nonrenewal, revocation, or suspension of the registration.

The information which I have provided in this application is truthful and complete. I understand that providing false and misleading information on items which are material in determining my qualifications may result in the voiding of the application, or denial or the revocation of any registration issued.

_____ _____

Date **Signature of Applicant**

VII.

REGISTERED SANITARIAN PROFESSIONAL REFERENCE FORM

PHOTOCOPY IF ADDITIONAL COPIES ARE NEEDED

Be sure to use a separate form for each organization or institution where the experience was gained. Be sure to submit experience sufficient to document two years of experience.

Name of Applicant:_____

Address of Applicant:_____
(Street No. or Box) (City) (State) (Zip)

The person certifying to his/her knowledge of the experience of the individual above shall complete the information below:

I, _____, certify that I have employed _____
(Employer) (Applicant)
from _____ to _____ and that I know of my own knowledge that said person was employed
(Month/Day/Year) (Month/Day/Year)
as follows and that his/her regularly assigned duties included work as a sanitarian:

1. Name and Address of Employer: _____
2. Briefly describe job responsibilities: _____

_____

3. Job Title: _____
4. Check type of establishment or office in which work is/was performed:
   ( ) City Employment ( ) County ( ) State ( ) Agency

   ( ) Other, Specify:_____
5. Total number of hours per week applicant worked in the above duties: _____
6. Other pertinent information:_____

On this _____ day of _____, 20_____, in _____, _____,
(City) (State)

I certify under penalty of perjury that the information submitted is true and correct.

STATE OF TEXAS ( )
COUNTY OF ( )

_____
Signature of Employer

Sworn to and subscribed before me this_____ day of _____, 20_____.

_____
Notary's Signature

NOTARY SEAL

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VIII.

SANITARIAN-IN-TRAINING SUPERVISION FORM

PHOTOCOPY IF ADDITIONAL COPIES ARE NEEDED

Be sure to use a separate form for each organization or institution where the experience was gained. Be sure to submit experience sufficient to document two years of experience.

Name of Applicant:_____

Address of Applicant:_____
(Street No. or Box) (City) (State) (Zip)

The person certifying to his/her knowledge of the experience of the individual above shall complete the information below:

I, _____, certify that I have employed _____
(Employer) (Applicant)
from _____ to _____ and that I know of my own knowledge that said person was employed as
(Month/Day/Year) (Month/Day/Year)
follows and that his/her regularly assigned duties included work as a sanitarian-in-training:

1. Name and Address of Employer: _____

2. Briefly describe job responsibilities: _____

_____

3. Job Title: _____

4. Check type of establishment or office in which work is/was performed:
   ( ) City Employment ( ) County ( ) State ( ) Agency

   ( ) Other, specify:_____

5. Total number of hours per week applicant worked in the above duties: _____

6. Other pertinent information:_____

On this _____ day of _____, 20_____, in _____, _____,
(City) (State)

I certify under penalty of perjury that the information submitted is true and correct.

STATE OF TEXAS ( )
COUNTY OF ( )

_____
Signature of Employer

Sworn to and subscribed before me this_____ day of _____, 20____.

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Request for Disability Accommodation

If you have a disability requiring appropriate accommodations in taking the state examination, be sure to complete this form along with the application. **In addition, attach a statement on letterhead stationery from a professional who is familiar with your disability.** This statement must describe the disability for which you require accommodation.

1. Do you have any disability-related needs that we should be made aware of in order to provide appropriate accommodations for the examination? ☐ YES ☐ NO If the answer is YES, please specify.

Disability: _____

_____

_____

2. Have you had any prior accommodations for your disability in an examination setting? ☐ YES ☐ NO
If you answer YES, specify the type of accommodation. Have a professional familiar with your disability complete this information, if needed.

Disability	Type of Test Accommodation

3. If you have NOT had prior accommodation for a test, what do you feel would aid you in taking the examination? If you cannot answer this question by yourself, have a professional who knows your disability and the type of accommodation you need help answer this question. This professional could be a physician, psychologist, rehabilitation counselor, or other professional.

Disability	Type of Test Accommodation

Please sign and date the bottom of this form. Make sure the professional who helps you complete the form also signs and dates this form. **Be sure to submit a statement on letterhead stationery from a professional who is familiar with your disability.**

_____ _____.
Signature (Applicant) Date

_____ _____.
Signature (Professional) Date