Texas Department of State Health Services
Emergency Medical Services
Medical Director Information Form
Revised 8/27/2015

Submit this form under an appropriate cover sheet to the appropriate address.
Cover sheets can be found at: http://www.dshs.state.tx.us/emstraumasystems/provfro.shtm
Fax Number: 512-834-6714 Email: EMSCert@dshs.state.tx.us

For assistance, contact the appropriate regional DSHS EMS staff.
See http://www.dshs.state.tx.us/emstraumasystems/provfro.shtm for contact information

Name of Legal Entity: _____

Legal Entity Assumed Name: _____

Name of Physician: _____

Medical License #: _____ Exp. date: _____

Date Medical Director Started: _____

Current Primary Practice Address: _____

City: _____ State: _____ Zip: _____

Email _____

Phone Number _____ FAX Number _____

I verify that I am a physician licensed in the State of Texas. I have read and am familiar with the Medical Practice Act and the Texas Medical Board rules regarding Emergency Medical Service at Title 22 of the Texas Administrative Code (TAC), Chapter 197, with the Department of State Health Services EMS statute at Chapter 773 of the Texas Health and Safety Code, and with EMS rules at Title 25 TAC, Chapter 157. I understand that I am responsible for all aspects of the operation of the above named legal entity concerning its provision of medical care.

Physician's Signature _____ **Date** _____

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 522.021, 522.023 and 559.004)