



FOR DSHS USE ONLY
 BUDGET/FUND: ZZ112-085

Remit #: _____

Remit Date: _____

Lead State Examination Registration

DO NOT WRITE IN THIS BOX – FOR DEPARTMENT USE ONLY

Rcvd Date: _____ Init. _____ Amt Rcvd: \$ _____ FY: _____ .Pymt Type: _____

This form must be completed in full and sent by mail with the \$50.00 examination fee and a copy of your training certificate(s). Send a check or money order payable to the "Department of State Health Services, account #ZZ112-085". DO NOT SEND CASH. EXAMINATION FEES ARE NON-REFUNDABLE. Registration forms will not be processed until all requirements for taking the state examination have been met. Please note that it may take three to four weeks for the department to process your application and payment. Once eligibility has been verified, a confirmation letter for admittance will be sent to you.

(Type or print all information clearly and do not leave any spaces blank)

 Last Name, First M.I. Social Security # Date of Birth

 Telephone # Fax # E-mail address

 Mailing address (include apartment #) City State Zip Code

Which exam attempt is this (mark one)?

License Type (mark one):

- Initial Examination
- 1st Re-examination
- 2nd Re-examination

- Supervisor
- Inspector
- Risk Assessor

Examination Date and Location (see examination calendar):

1st choice: _____ 2nd choice: _____

Mailing address:

Department of State Health Services - MC2003
 Environmental & Sanitation Licensing Group
 PO Box 149347
 Austin, Texas 78714-9347

Overnight mailing address: (FedEx, UPS, etc.)

Department of State Health Services – MC2003
 Environmental & Sanitation Licensing Group
 1100 W. 49th St.
 Austin, Texas 78756

Disability accommodations: A disability is a physical or mental impairment that substantially limits one or more major life activities. If you have a disability and need a reasonable modification we will make every effort to accommodate your needs (Policy Circular C-039: Reasonable Modifications in the Licensing and Certification Examination Process - <http://www.dshs.state.tx.us/news/circulars/C-039.shtml>). Please fill out a Reasonable Modification Request form, gather medical and diagnostic documentation that describes the nature of your disability and modifications you request, and submit both with this application.

CERTIFICATION: I certify that I have read and understand the applicable rules and agree to comply with them. I understand that it is a violation of DSHS rules and the Texas Penal Code §37.10 to submit any false or fraudulent information or documents. I also understand that disclosure of my social security number is mandatory under Family Code Chapter 231.302.(c)(1), and will be used for identification and reporting purposes required by law. All information I have provided on this application is true, correct, and complete to the best of my knowledge. I acknowledge that any falsification or misrepresentation will result in the denial of my admission into the testing facility and any misconduct during the examination will result in my dismissal from the testing facility. I further agree that I have no right to reproduce, distribute, or sell any of the examination.

 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 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).