



DO NOT WRITE IN THIS BOX – DEPARTMENT USE ONLY	
BUDGET/FUND: ZZ112-085	Rcvd Date: _____
REMIT #: _____	Amt Rcvd: \$ _____
Remit Date: _____	

Lead State Examination Registration

You must fully complete this form. Send it by mail with your examination fee(s) and a copy of your training certificates (Initial and all Refreshers). 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.

EXAM ATTEMPT		LICENSE TYPE		EXAM FEE
INITIAL EXAM	<input type="checkbox"/>	SUPERVISOR	<input type="checkbox"/>	\$50
1 st RE-EXAMINATION	<input type="checkbox"/>	INSPECTOR	<input type="checkbox"/>	\$50
2 nd RE-EXAMINATION	<input type="checkbox"/>	RISK ASSESSOR	<input type="checkbox"/>	\$50

LAST NAME		FIRST NAME		MIDDLE NAME	
BIRTH DATE	SOCIAL SECURITY #	PHONE #	EMAIL ADDRESS		
MAILING ADDRESS			CITY	STATE	ZIP CODE
PREFERRED EXAM DATE & LOCATION			BACKUP EXAM DATE & LOCATION		

CERTIFICATION: I certify I understand it is a violation of DSHS rules and the Texas Penal Code §37.10 to submit any false or fraudulent information or documents. All information I provided on this application is true, correct, and complete to the best of my knowledge. I acknowledge 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 I have no right to reproduce, distribute, or sell any of the examination.

DATE	SIGNATURE