



This form is used to determine if the Emergency Medical Service (EMS) Applicant/Certificant/Licensee is compliant with his or her community supervision/probation requirements. Please return the completed form to:
MAIL: Department of State Health Services, EMS Central Group, Mail Code 1876, P.O. Box 149347, Austin, Texas 78714-9347 or **FAX:** 512-834-6713.

SECTION 1: To be completed by EMS Applicant/Certificant/Licensee

LAST	FIRST	MIDDLE
NAME:		
SOCIAL SECURITY NUMBER:		DATE OF BIRTH: (mm/dd/yy)

SECTION 2: To be completed by EMS Applicant/Certificant/Licensee

I _____ authorize the Department of State Health Services, EMS Compliance and Quality Assurance, to receive information related to my community supervision pursuant to Chapter 773 of the Health and Safety Code which requires evidence to assist in determining the fitness to perform the duties and discharge the responsibilities of emergency medical service personnel.

(Signature of Applicant)

(Date)

SECTION 3: To be completed by Community Supervision Officer (CSO) Please include any other documentation pertinent to the completion of this section or additional sheets if necessary.

Is the EMS applicant/certificant/licensee in compliance with supervision? ___ Yes ___ No
If answered no, please provide an explanation below:

(CSO Printed Name)

(Signature of CSO is required)

(Date)

(CSO Phone #)