Vision, Hearing and Spinal Screening Training
Return Checklist

Vision & Hearing Training:

☐ **Attendance Sheets –** Please notate on attendance sheet if any participant fails or does not complete the training workshop.
- ☐ One for Vision
- ☐ One for Hearing

☐ **Card Stubs** – (**return large portion of card**) *Note: number of cards must match number of attendees.*
☐ **Evaluations** – each participant should fill out an evaluation

Spinal Screening Training:

☐ **Attendance Sheets –** Please notate on attendance sheet if any participant fails or does not complete the training workshop.
☐ **Card Stubs** – (**return large portion of card**) Note: number of cards must match number of attendees.
☐ **Evaluations** – each participant should fill out an evaluation

Send ALL Materials to:

Texas Department of State Health Services
Maternal and Child Health Section
Health Screening Group
Mail Code 1818
1100 West 49th Street
PO BOX 149347
Austin TX 78714-9347

Contact Customer Service:

Email:
vhssprogram@dshs.texas.gov

Phone: 512-776-7420

Issues or Comments:

Completed by: _____ **Date Sent:** _____

☐ **Vision** **Vision and Hearing Screening Workshop Attendance Sheet** ☐ **Hearing**

Date _____ Basic ☐ Re-certification ☐ Number of Participants _____ HSR _____

Trainer _____ Zip Code _____ Required: Trainer's Phone # _____

	Name (PRINT LEGIBLY)	**Signature**	**E-Mail Address**	**High School Graduate/GED**
1				Y ☐ / N ☐
2				Y ☐ / N ☐
3				Y ☐ / N ☐
4				Y ☐ / N ☐
5				Y ☐ / N ☐
6				Y ☐ / N ☐
7				Y ☐ / N ☐
8				Y ☐ / N ☐
9				Y ☐ / N ☐
10				Y ☐ / N ☐
11				Y ☐ / N ☐
12				Y ☐ / N ☐
13				Y ☐ / N ☐
14				Y ☐ / N ☐
15				Y ☐ / N ☐

Note to Trainer: After the workshop please mail this attendance sheet, along with evaluations and completed large portion of the registration cards to: Vision, Hearing and Spinal Screening, Public Health Screening and Services Coordination Section, 1100 West 49th Street, PO Box 149347, Austin, TX 78714-9347 Rev 07/2025

REQUEST FOR VISION & HEARING WORKSHOP MATERIALS

PLEASE ALLOW AT LEAST THREE (3) WEEKS FOR PROCESSING

Please notify us immediately if you have not received your materials by **one week prior** to your scheduled workshop date. *

☐ BASIC ☐ RECERTIFICATION

TODAY'S DATE_____

VISION: Date_____ Number _____

HEARING: Date_____ Number _____

NOTE: NOTIFY US, IN AMPLE TIME, IF WORKSHOP DATE CHANGES.

PLACE OF WORKSHOP_____

NAME OF INSTRUCTOR _____

NAME OF CONTACT PERSON _____
(If other than instructor.)

PHONE NUMBER _____

EMAIL _____

SHIP MATERIALS TO:

NAME_____

FACILITY _____

STREET **(No P.O. Box)** _____

CITY & STATE_____ZIPCODE_____

Email request to: vhssprogram@dshs.texas.gov

If you have questions, please call: **512-776-7420**