APPLICATION FOR INSTRUCTOR OF SPINAL SCREENERS

_____

Last Name First Name M.I. Title

MAILING ADDRESS (PROFESSIONAL)

_____ (_____)_____

Employer Telephone Number

_____

Street City State Zip Code

EDUCATION: University or College Dates Degree(s) Earned

_____ _____ _____

_____ _____ _____

EXPERIENCE: Briefly summarize experience in hearing and/or vision screening.

_____

_____

WORKSHOP OPERATIONS:

Describe limitations applicable to your workshops (e.g., confined to certain geographical areas, certain months only, limited to instructor's institution or organization).

_____

_____

_____

Applicant's Signature

Complete and Email to:
VhssProgram@dshs.texas.gov

_____

E-mail Address

_____

Date

Renewal:

☐ YES---☐NO Remain instructor of Spinal Screeners.

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 https://statutes.capitol.texas.gov/Docs/GV/htm/GV.559.htm for more information on Privacy Notification. (Reference: Government Code, Section 522.021, 522.023 and 559.004)