



Regulatory Licensing Unit
EMS Certification & Licensing Group



EMS Wallet Card
Replacement Application

All information given on this application is considered public record, with the exception of social security number*.

To request a duplicate EMS wallet card, submit completed form with check or money order payable to Texas Dept of State Health Services.

Mail to: Dept of State Health Services, ATTN: ZZ100-160 EMS
1100 West 49th Street, Austin, TX 78756-3199

For DSHS Use Only
ZZ100-160
Receipt #
Date
Amount

Section 1 - Personnel Data TYPE OR PRINT IN BLACK INK

Requesting duplicate wallet card for the following level: ECA EMT EMT-I EMT-P Lic-P
Coordinator EMS Instructor EMS Information Operator Instructor
Enclosing \$10 Exempt from fee - Complete Volunteer Sign-Off below.
Print Last Name First Name Middle Name Social Security number*
Mailing Address: Street, Apt Number or PO Box City State Zip
Home Phone Business Phone Date of Birth
Alternate home address**
** This may be desired by candidates whose employer mandates the business address as the mailing address.
Are you associated with a Texas licensed EMS Provider or registered 1st Responder? Yes or No
If yes, are you: Salaried - Employment date: Volunteer - Complete Volunteer Sign-Off below.
* Disclosure of your social security number is mandatory under Family Code, Chapter 232

Section 2 - Volunteer Sign-Off - Complete if applicable

If you are claiming fee exempt status, this section should be completed by approved EMS Provider or FRO administrator.
This candidate is exempt from the payment of fees because he/she actively provides emergency medical care for our organization, and does not receive compensation*** for providing these services.
Signature of provider or FRO administrator Print signed name
***Compensation does not include reimbursement for actual expenses for medical supplies, gasoline, clothing, meals and insurance incurred while volunteering.
Provider or FRO name: City:
DSHS license or registration number: Phone:

Section 3 - Signature and Date

I swear or affirm that all information in this application is true and correct. I further certify by signature hereon, that I am authorized to execute this document. I am not delinquent in the payment of any child support owed under Chapter 232, Family Code. I further certify that I have read and understood Chapter 773 of the Health and Safety Code, the applicable provisions of 25 TAC, Chapter 157, and agree to abide by them.
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 collect 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 522.021,

