TEXAS Health and Human Services | Texas Department of State Health Services

EMS COMMUNITY SUPERVISION FORM

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/Trauma Systems- Central Group, Mail Code 1876, P.O. Box 149347, Austin, Texas 78714-9347 or **FAX:** 512-834-6713.

TYPE OR PRINT IN BLACK INK

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 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 #)