MAEMSA INDIVIDUAL MEDICAL PROVIDER CREDENTIAL APPLICATION

Full Legal Name of Individual applying for permit	
Address	
Phone Number	
Email Address	
Texas DSHS Providers License Number	
Texas DSHS Providers License expiration date	
Medical Director's Name	
Medical Director's Contact Information (Phone / Email)	
Certified providers for each level: (ECA / EMT-B / EMT-P / RN / LVN)	
Name of Organization which you are employed / providing services for.	
EMS Personnel Status: (Paid / Volunteer/Mixed)	

Email: PERMITS@MEDSTAR911.ORG

Mail: The Metropolitan Area EMS Authority
Attention: Compliance Officer
Fort Worth, Texas 76116
Phone: (817) 923-3700 Extension: 226

I submit this application on behalf of the above named legal entity, to the Metropolitan Area EMS Authority DBA: MedStar Mobile Healthcare. I hereby affirm and declare that all information submitted on this form and attached supplemental documents are true and correct. It is understood that any false information given or misrepresentation made in this application or other requested documents may result in revocation or denial of credentialing. I have read, understand, and agree to abide by Chapter 773 of the Texas Health and Safety Code and Title 25 of the Texas Administrative Code, Chapter 157 and Title 22 of the Texas Health and safety Code, Chapter 197.

Name of Submitter: _____

Signature of Submitter: _____ Date: _____