

TEXAS MILITARY FORCES
Texas State Guard Medical Brigade
Galveston Medical Response Group
2885 Smokey Lake Lane Dickinson, Texas 77539
281 415 7204

We welcome your interest in the Galveston Medical Response Group. We try to make it as easy as possible to join by processing applications during our drills. You are welcome to join us a guest to observe and ask more questions.

Alpha Company drills are on the 2nd and 4th Tuesdays of the month at 6pm at the La Marque National Guard Armory.

Bravo Company drills are on the 1st Saturday of the month, temporarily at the Angleton-Danbury Hospital in Angleton. Other Companies are currently forming in the surrounding areas including Beaumont/Port Arthur, Bryan/College Station, Huntsville, Bay City/Wharton, Pasadena, The Woodlands/Conroe, and Baytown.

If you would like to proceed with making an application, you may fill out this packet and bring all your pertinent documents including driver's license, social security card, diplomas, unofficial transcripts, certifications, licenses and any emergency courses you may have taken, to the next drill, which would be a great start. The rest of the application is rather brief. It will be finished up later and then the signature pages will be either mailed to you or brought to the next drill. It usually takes several months before you will be ready for swearing-in, so we like to get things going as quickly as we can.

If you are applying for one of our start-up Companies that have not started drills yet, please mail your completed application and color copies of all your documents to: MAJ Kathryn Willingham DVM, 20723 Hwy 36, Brazoria, TX 77422.

Our Group's website is www.gcmrg.us

On the left-hand side there is a link about joining which includes a checklist for applicants. This will be helpful if you are ready to gather materials and make an application.

The main website for the Texas State Guard is <http://www.txsg.state.tx.us/>

Additional information on the Texas Medical Brigade can be found at <http://tmb.txsg.state.tx.us/>

If you have any questions, please let one of us know and we will be happy to assist you.

SGT Grant A. Threatt, Recruiter, / GMRG, Alpha Company 832-515-3338 /
grant.threatt@txsg.state.tx.us

SGT Jason Wadley, Recruiter, GMRG, Bravo Company 979-236-5170 /
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Texas Military Forces
Joint Force Headquarters
Adjutant General's Department
Austin, Texas 78763

JFTX-J3

09 March 2011

MEMORANDUM FOR Texas Military Forces
SUBJECT: Mexico Travel Policy - JFTX P11-07

APPLICABILITY. This policy applies to all TXMF personnel in a full-time military duty status, in a paid military duty status (Annual Training, Inactive Duty Training), and technicians travelling in an official capacity. Texas State Guard, State of Texas employees, contractors, families and technicians are strongly encouraged to follow this policy.

POLICY. Effective immediately, all TXMF personnel in a full-time military duty status, in a paid military duty status, or technicians (travelling in an official capacity) are prohibited from travel to Mexico, including popular tourist destinations.

a. Voluntary compliance by M-day or traditional personnel (not in military status), technicians (not travelling in an official capacity), Texas State Guard, State of Texas employees, contractors and families is strongly encouraged.

b. Personnel not subject to mandatory compliance that elect not to follow the travel restrictions should carefully review the Department of State Travel Alert and implement the cautionary practices recommended.

REQUIREMENTS.

a. Exceptions to policy must be submitted in writing and approved by the first O6 (Colonel) level commander, or, for separate commands the first O5 (Lieutenant Colonel) commander in the service member's chain of command.

b. Before commanders approve requests for travel to Mexico, they must ensure that requestors have: (1) completed Antiterrorism (AT) Level I training within the previous year, (2) reviewed Mexico Travel Alerts and Warnings from the Department of State (DOS), and (3) received a Country Threat Briefing.

EXPIRATION. This policy supercedes JFTX Policy 10-05 dated 01FEB10, and will remain in effect until superseded or rescinded.

John F. Nichols
Major General, TXANG
Adjutant General

I have read and understand this policy.

_____ Printed name

_____ Signature

_____ Date

ENLISTMENT RECORD

SECTION I - APPLICATION FOR ENLISTMENT

1. NAME OF APPLICANT (Last, First Middle)			2. SOCIAL SECURITY NUMBER		
3. RESIDENTIAL ADDRESS (Street, City, State, Zip)			4. HOME PHONE NUMBER () -		
5. NAME OF EMPLOYER (Include Self Employment)		6. JOB TITLE	7. MOBILE PHONE NUMBER () -		
8. DATE OF BIRTH (DD, MMM, YYYY)	9. CITIZENSHIP	10. SEX M _____ F _____	11. HEIGHT _____ inches	12. WEIGHT	13. BLOOD TYPE
14. COLOR OF EYES	15. COLOR OF HAIR	16. MARITAL STATUS	17. RACE (Ethnic data is maintained in accordance with the requirements of 42 U S C) <input type="checkbox"/> WHITE <input type="checkbox"/> AFRICAN AMERICAN <input type="checkbox"/> HISPANIC <input type="checkbox"/> AMERICAN INDIAN <input type="checkbox"/> ASIAN AMERICAN <input type="checkbox"/> OTHER (SPECIFY) _____		
18. TEXAS STATE GUARD UNIT		19. INITIAL ASSIGNMENT			

20. CIVILIAN EDUCATION (List High Schools, Trade Schools & Colleges)

NAME OF SCHOOL	LOCATION (City & State)	YEARS COMPLETED	DEGREE OR RATING

21. PRIOR MILITARY SERVICE (List each major period of duty. Non-prior service, list NONE)

Date From	Date To	Highest Grade	Armed Force	Duty Assignment	Unit

22. AWARDS and DECORATIONS (Inclusive of Texas State Guard Awards)

SECTION I - APPLICATION FOR ENLISTMENT (cont.)

23. MILITARY EDUCATION

COURSE NAME	LOCATION	YEAR COMPLETED	QUALIFICATION (If Applicable)

24. Have you ever been arrested? Yes ___ No ___ If yes, provide a list of charges and disposition below:

CHARGE	DATE	DISPOSITION
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_____	_____	_____
_____	_____	_____

I certify that the information in Section I is a true and correct statement of my personal history, educational background and military experience. I hereby voluntarily enlist for an indefinite period, as an enlisted member of the Texas State Guard, under the conditions prescribed by law, until discharged by proper authority. I authorize any law enforcement agency to release, to an officer of the Texas State Guard, any record of criminal history on file, concerning me.

_____ Date

_____ Signature of Volunteer

SECTION II - CERTIFICATION AND OATH OF ENLISTMENT

1. CERTIFICATION BY UNIT COMMANDER

Through interview and examination of educational and military records, I verify the validity of the statements made in the application for enlistment, and approve enlistment in the rank of:

_____	_____
INITIAL RANK (to be determined by Personnel Officer)	PRINTED NAME AND GRADE

2. OATH OF ENLISTMENT

I, _____, do solemnly swear that I will bear true faith and allegiance to the State of Texas and to the United States of America; that I will serve them honestly and faithfully against all their enemies whomsoever, and that I will obey the orders of the Governor of Texas, and the orders of the officers appointed over me, according to the laws, rules and articles for the government of the Military Forces of the State of Texas.

Subscribed and sworn before me at _____, Texas on this _____ day of _____ 20 _____

_____ SIGNATURE

_____ SIGNATURE OF OFFICER ADMINISTERING OATH

_____ PRINTED NAME AND GRADE

SECTION III - RECORD OF PRIOR SERVICE IN TXSG

EFFECTIVE DATE	RANK	DUTY ASSIGNED	TEXAS STATE GUARD UNIT	ORDERS NUMBERS & DATE



Texas State Guard

Personnel Database Management System

Add New Member - INPUT FORM

Please enter basic contact information for new member.

LAST Name:	<input type="text"/>	SSN:	<input type="text"/>
FIRST Name:	<input type="text"/>	DOB:	<input type="text"/>
MIDDLE Name:	<input type="text"/>	Address:	<input type="text"/>
Suffix:	<input type="text"/>	City:	<input type="text"/>
Home Phone:	<input type="text"/>	State/ZIP:	<input type="text"/>
Mobile Phone:	<input type="text"/>	Home Email:	<input type="text"/>

Add the member's physical information below. ALL FIELDS ARE REQUIRED

Gender:	<input type="text"/>	Race:	<input type="text"/>
Height:	<input type="text"/>	Eye Color:	<input type="text"/>
Weight:	<input type="text"/>	Hair Color:	<input type="text"/>
Blood Type:	<input type="text"/>		

Rank Level and Rank to be filled out by Personnel Officer.

Military Type:	<input type="text"/>
Rank Level:	<input type="text"/>
Rank:	<input type="text"/>
Date of Rank /Initial Entry:	<input type="text"/>

Choose which Unit the member will be assigned to.

First select a Top-Level Unit:

Now select a Subordinate Unit, Detachment or HQ Unit:

REPORT OF MEDICAL HISTORY
 (This information is for official and medically confidential use only
 and will not be released to unauthorized persons.)

OMB No. 0704-0413
 OMB approval expires
 Mar 31, 2010

The public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Services Directorate (0704-0413). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM AS INDICATED ON PAGE 2.

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397 (SSAN).

PRINCIPAL PURPOSE(S): To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed Forces.

ROUTINE USE(S): None.

DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.

WARNING: The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confinement or a \$10,000 fine or both), to anyone making a false statement. If you are selected for enlistment, commission, or entrance into a commissioning program based on a false statement, you can be tried by military courts-martial or meet an administrative board for discharge and could receive a less than honorable discharge that would affect your future.

1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	2. SOCIAL SECURITY NUMBER	3. TODAY'S DATE (YYYYMMDD)
4.a. HOME ADDRESS (Street, Apartment No., City, State, and ZIP Code)	5. EXAMINING LOCATION AND ADDRESS (Include ZIP Code)	
b. HOME TELEPHONE (Include Area Code)		

X ALL APPLICABLE BOXES:			7.a. POSITION (Title, Grade, Component)
6.a. SERVICE	6.b. COMPONENT	6.c. PURPOSE OF EXAMINATION	b. USUAL OCCUPATION
<input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force	<input type="checkbox"/> Active Duty <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard	<input type="checkbox"/> Enlistment <input type="checkbox"/> Medical Board <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Commission <input type="checkbox"/> Retirement <input type="checkbox"/> Retention <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> Separation <input type="checkbox"/> ROTC Scholarship Program	

8. CURRENT MEDICATIONS (Prescription and Over-the-counter)	9. ALLERGIES (Including insect bites/stings, foods, medicine or other substance)
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Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 on Page 2.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO		YES	NO
10.a. Tuberculosis	<input type="radio"/>	<input type="radio"/>	12. (Continued)	<input type="radio"/>	<input type="radio"/>
b. Lived with someone who had tuberculosis	<input type="radio"/>	<input type="radio"/>	f. Foot trouble (e.g., pain, corns, bunions, etc.)	<input type="radio"/>	<input type="radio"/>
c. Coughed up blood	<input type="radio"/>	<input type="radio"/>	g. Impaired use of arms, legs, hands, or feet	<input type="radio"/>	<input type="radio"/>
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.	<input type="radio"/>	<input type="radio"/>	h. Swollen or painful joint(s)	<input type="radio"/>	<input type="radio"/>
e. Shortness of breath	<input type="radio"/>	<input type="radio"/>	i. Knee trouble (e.g., locking, giving out, pain or ligament injury, etc.)	<input type="radio"/>	<input type="radio"/>
f. Bronchitis	<input type="radio"/>	<input type="radio"/>	j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint	<input type="radio"/>	<input type="radio"/>
g. Wheezing or problems with wheezing	<input type="radio"/>	<input type="radio"/>	k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc.	<input type="radio"/>	<input type="radio"/>
h. Been prescribed or used an inhaler	<input type="radio"/>	<input type="radio"/>	l. Bone, joint, or other deformity	<input type="radio"/>	<input type="radio"/>
i. A chronic cough or cough at night	<input type="radio"/>	<input type="radio"/>	m. Plate(s), screw(s), rod(s) or pin(s) in any bone	<input type="radio"/>	<input type="radio"/>
j. Sinusitis	<input type="radio"/>	<input type="radio"/>	n. Broken bone(s) (cracked or fractured)	<input type="radio"/>	<input type="radio"/>
k. Hay fever	<input type="radio"/>	<input type="radio"/>	13.a. Frequent indigestion or heartburn	<input type="radio"/>	<input type="radio"/>
l. Chronic or frequent colds	<input type="radio"/>	<input type="radio"/>	b. Stomach, liver, intestinal trouble, or ulcer	<input type="radio"/>	<input type="radio"/>
11.a. Severe tooth or gum trouble	<input type="radio"/>	<input type="radio"/>	c. Gall bladder trouble or gallstones	<input type="radio"/>	<input type="radio"/>
b. Thyroid trouble or goiter	<input type="radio"/>	<input type="radio"/>	d. Jaundice or hepatitis (liver disease)	<input type="radio"/>	<input type="radio"/>
c. Eye disorder or trouble	<input type="radio"/>	<input type="radio"/>	e. Rupture/hernia	<input type="radio"/>	<input type="radio"/>
d. Ear, nose, or throat trouble	<input type="radio"/>	<input type="radio"/>	f. Rectal disease, hemorrhoids or blood from the rectum	<input type="radio"/>	<input type="radio"/>
e. Loss of vision in either eye	<input type="radio"/>	<input type="radio"/>	g. Skin diseases (e.g. acne, eczema, psoriasis, etc.)	<input type="radio"/>	<input type="radio"/>
f. Worn contact lenses or glasses	<input type="radio"/>	<input type="radio"/>	h. Frequent or painful urination	<input type="radio"/>	<input type="radio"/>
g. A hearing loss or wear a hearing aid	<input type="radio"/>	<input type="radio"/>	i. High or low blood sugar	<input type="radio"/>	<input type="radio"/>
h. Surgery to correct vision (RK, PRK, LASIK, etc.)	<input type="radio"/>	<input type="radio"/>	j. Kidney stone or blood in urine	<input type="radio"/>	<input type="radio"/>
12.a. Painful shoulder, elbow or wrist (e.g. pain, dislocation, etc.)	<input type="radio"/>	<input type="radio"/>	k. Sugar or protein in urine	<input type="radio"/>	<input type="radio"/>
b. Arthritis, rheumatism, or bursitis	<input type="radio"/>	<input type="radio"/>	l. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)	<input type="radio"/>	<input type="radio"/>
c. Recurrent back pain or any back problem	<input type="radio"/>	<input type="radio"/>	14.a. Adverse reaction to serum, food, insect stings or medicine	<input type="radio"/>	<input type="radio"/>
d. Numbness or tingling	<input type="radio"/>	<input type="radio"/>	b. Recent unexplained gain or loss of weight	<input type="radio"/>	<input type="radio"/>
e. Loss of finger or toe	<input type="radio"/>	<input type="radio"/>	c. Currently in good health (If no, explain in Item 29 on Page 2.)	<input type="radio"/>	<input type="radio"/>
			d. Tumor, growth, cyst, or cancer	<input type="radio"/>	<input type="radio"/>

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER
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Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 below.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO		YES	NO	
15.a. Dizziness or fainting spells	<input type="radio"/>	<input type="radio"/>	19. Have you been refused employment or been unable to hold a job or stay in school because of:	<input type="radio"/>	<input type="radio"/>	
b. Frequent or severe headache	<input type="radio"/>	<input type="radio"/>		a. Sensitivity to chemicals, dust, sunlight, etc.	<input type="radio"/>	<input type="radio"/>
c. A head injury, memory loss or amnesia	<input type="radio"/>	<input type="radio"/>		b. Inability to perform certain motions	<input type="radio"/>	<input type="radio"/>
d. Paralysis	<input type="radio"/>	<input type="radio"/>		c. Inability to stand, sit, kneel, lie down, etc.	<input type="radio"/>	<input type="radio"/>
e. Seizures, convulsions, epilepsy or fits	<input type="radio"/>	<input type="radio"/>		d. Other medical reasons <i>(If yes, give reasons.)</i>	<input type="radio"/>	<input type="radio"/>
f. Car, train, sea, or air sickness	<input type="radio"/>	<input type="radio"/>		20. Have you ever been treated in an Emergency Room? <i>(If yes, for what?)</i>		
g. A period of unconsciousness or concussion	<input type="radio"/>	<input type="radio"/>		21. Have you ever been a patient in any type of hospital? <i>(If yes, specify when, where, why, and name of doctor and complete address of hospital.)</i>		
h. Meningitis, encephalitis, or other neurological problems	<input type="radio"/>	<input type="radio"/>		22. Have you ever had, or have you been advised to have any operations or surgery? <i>(If yes, describe and give age at which occurred.)</i>		
16.a. Rheumatic fever	<input type="radio"/>	<input type="radio"/>	23. Have you ever had any illness or injury other than those already noted? <i>(If yes, specify when, where, and give details.)</i>			
b. Prolonged bleeding <i>(as after an injury or tooth extraction, etc.)</i>	<input type="radio"/>	<input type="radio"/>	24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? <i>(If yes, give complete address of doctor, hospital, clinic, and details.)</i>			
c. Pain or pressure in the chest	<input type="radio"/>	<input type="radio"/>	25. Have you ever been rejected for military service for any reason? <i>(If yes, give date and reason for rejection.)</i>			
d. Palpitation, pounding heart or abnormal heartbeat	<input type="radio"/>	<input type="radio"/>	26. Have you ever been discharged from military service for any reason? <i>(If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)</i>			
e. Heart trouble or murmur	<input type="radio"/>	<input type="radio"/>	27. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? <i>(If yes, specify what kind, granted by whom, and what amount, when, why.)</i>			
f. High or low blood pressure	<input type="radio"/>	<input type="radio"/>	28. Have you ever been denied life insurance?			
17.a. Nervous trouble of any sort <i>(anxiety or panic attacks)</i>	<input type="radio"/>	<input type="radio"/>	29. EXPLANATION OF "YES" ANSWER(S) <i>(Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)</i> <div style="text-align:center; margin-top: 10px;"><i>examples of "Yes" answer above:</i></div> <p>16f. 2003 High blood pressure. Dr. Keolassy. LAFB outpatient clinic, controlled thru medication.</p> <p>23. 1965 Severe heat prostration, Dr. McKinstry, Jefferson Hosp. 30 days in hosp. no recurrence.</p> <p>26. 1967 ETS US Army, Honorable.</p> <p>27. 1989 VA disability 60% for service incurred injury, retain full use of all extremities.</p>			
b. Habitual stammering or stuttering	<input type="radio"/>	<input type="radio"/>				
c. Loss of memory or amnesia, or neurological symptoms	<input type="radio"/>	<input type="radio"/>				
d. Frequent trouble sleeping	<input type="radio"/>	<input type="radio"/>				
e. Received counseling of any type	<input type="radio"/>	<input type="radio"/>				
f. Depression or excessive worry	<input type="radio"/>	<input type="radio"/>				
g. Been evaluated or treated for a mental condition	<input type="radio"/>	<input type="radio"/>				
h. Attempted suicide	<input type="radio"/>	<input type="radio"/>				
i. Used illegal drugs or abused prescription drugs	<input type="radio"/>	<input type="radio"/>				
18. FEMALES ONLY. Have you ever had or do you now have:						
a. Treatment for a gynecological (female) disorder	<input type="radio"/>	<input type="radio"/>				
b. A change of menstrual pattern	<input type="radio"/>	<input type="radio"/>				
c. Any abnormal PAP smears	<input type="radio"/>	<input type="radio"/>				
d. First day of last menstrual period (YYYYMMDD)						
e. Date of last PAP smear (YYYYMMDD)						

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY."

REQUEST PERTAINING TO MILITARY RECORDS

To ensure the best possible service, please thoroughly review the accompanying instructions before filling out this form. Please print clearly or type. If you need more space, use plain paper.

SECTION I - INFORMATION NEEDED TO LOCATE RECORDS (Furnish as much as possible.)

1. NAME USED DURING SERVICE (last, first, and middle)	2. SOCIAL SECURITY NO.	3. DATE OF BIRTH	4. PLACE OF BIRTH	
5. SERVICE, PAST AND PRESENT (For an effective records search, it is important that all service be shown below.)				
BRANCH OF SERVICE	DATES OF SERVICE		CHECK ONE	SERVICE NUMBER DURING THIS PERIOD (If unknown, write "unknown")
	DATE ENTERED	DATE RELEASED	OFFICER	
a. ACTIVE SERVICE				
b. RESERVE SERVICE				
c. NATIONAL GUARD				
6. IS THIS PERSON DECEASED? If "YES" enter the date of death.		7. IS (WAS) THIS PERSON RETIRED FROM MILITARY SERVICE?		
NO YES _____		NO YES _____		

SECTION II - INFORMATION AND/OR DOCUMENTS REQUESTED

1. REPORT OF SEPARATION (DD Form 214 or equivalent). This contains information normally needed to verify military service. A copy may be sent to the veteran, the deceased veteran's next of kin, or other persons or organizations if authorized in Section III, below. NOTE: If more than one period of service was performed, even in the same branch, there may be more than one Report of Separation. Be sure to show EACH year that a Report of Separation was issued, for which you need a copy.

An **UNDELETED** Report of Separation is requested for the year(s) _____

This normally will be a copy of the full separation document including such sensitive items as the character of separation, authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and dates of time lost. An undeleted version is ordinarily required to determine eligibility for benefits.

A **DELETED** Report of Separation is requested for the year(s) _____

The following information will be deleted from the copy sent: authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and for separations after June 30, 1979, character of separation and dates of time lost.

2. OTHER INFORMATION AND/OR DOCUMENTS REQUESTED _____

3. PURPOSE (Optional - An explanation of the purpose of the request is strictly voluntary. Such information may help the agency answering this request to provide the best possible response and will in no way be used to make a decision to deny the request.) _____

SECTION III - RETURN ADDRESS AND SIGNATURE

1. REQUESTER IS:

Military service member or veteran identified in Section I, above
 Next of kin of deceased veteran _____ (relation)

Legal guardian (must submit copy of court appointment)
 Other (specify) _____

2. SEND INFORMATION/DOCUMENTS TO:
 (Please print or type. See item 3 on accompanying instructions.)

3. AUTHORIZATION SIGNATURE REQUIRED (See item 2 on accompanying instructions.) I declare (or certify, verify, or state) under penalty of perjury under the laws of the United States of America that the information in this Section III is true and correct.

Name _____
 Street _____ Apt. _____
 City _____ State _____ Zip Code _____

Signature (Please do not print.) _____
 Date of this request _____ Daytime phone _____
 Email address _____



Texas State Guard

This document is your **FAST Fingerprint Pass** for a national criminal history record check. You must schedule a fingerprint appointment by visiting www.ibtfingerprint.com or by calling 1-888-467-2080. Cost for fingerprinting is **\$9.95** and you may pay for **FAST** services online with a credit card or onsite with a check or money order only. Credit cards will not be accepted onsite.

1. Log on to www.ibtfingerprint.com and select **Texas**
2. Select Language option: **English or Espanol**
3. Enter: **First and Last Name**
4. Select: **All Others**
5. Select: **Option A – Electronic Submission**
6. Select: **Yes, I have a FAST Fingerprint Pass**
7. Enter: [TX923486Z](http://www.ibtfingerprint.com) when prompted for ORI#
8. Follow the prompts to enter your personal information and select service location, date and time.
9. Bring this completed form with you to your appointment.

Section One: Agency Information

Agency ORI: [TX923486Z](http://www.ibtfingerprint.com) Agency

Name: Texas State Guard

Original TCN: _____
(If resubmission for rejected fingerprints)

Section Two: Applicant Information (To be completed by Applicant)

Applicant Last Name: _____ First Name: _____ Middle Name: _____
(please print)

Sex: Male Female Race: _____ Ethnicity: _____ Skin Tone: _____
(W, B, A, I, O) (Hispanic or Non-Hispanic)

Date of Birth: _____ Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____
(feet and inches)

Place of Birth: _____
(State or Country)

Home Address: _____
Street Address City State Zip

I certify the applicant information provided above is true and accurate. I authorize the Texas Department of Public Safety to access Texas and Federal criminal history record information that pertains to me and disseminate that information to the above designated Authorized Agency or Qualified Entity through the DPS Fingerprint-based Applicant Clearinghouse of Texas and as authorized by Texas Government Code Chapter 411 and any other applicable state or federal statute or policy.

Signature _____ Date _____

Section 3: Service Center Information (To be completed by FAST Live Scan Operator)

Date Prints Taken _____ Amount Charged For Service: _____

Paid by: Check Money Order Visa MasterCard Billing Acct _____

TCN _____

I HAVE COMPARED THE GOVERNMENT-ISSUED IDENTIFICATION PRESENTED BY THE APPLICANT AND ATTEST THAT TO MY BEST DETERMINATION, I HAVE FINGERPRINTED THE SAME PERSON.

Printed Name of LSO: _____

Signature of LSO: _____

GALVESTON MEDICAL RESPONSE GROUP EMERGENCY CONTACT INFORMATION

(please TYPE in the requested information where indicated)

Rank

Name (Last, First):

Physical Address:

City

State

Zip

Phones(s) Home

Work

Cell

Cell Carrier: (Verizon, AT&T, Alltel, T-Mobile etc.):

Are you able to send/receive text messages on your cell? Y Or N

Your employer:

Usual Work hours and Days: Hours: Days:

EMERGENCY CONTACT PERSON(S) - THESE INDIVIDUALS SHOULD KNOW WHERE YOU ARE OR HOW TO CONTACT YOU

1 Name
Relationship
Home #
Work #
Cell # Send/Receive text msgs? Y or N

2 Name
Relationship
Home #
Work #
Cell # Send/Receive text msgs? Y or N

3 Name
Relationship
Home #
Work #
Cell # Send/Receive text msgs? Y or N

Vehicle Information (this is the vehicle you NORMALLY drive to drill)

Make

Model

Color

Year

License Plate #