

CITY OF AUSTIN POLICE DEPARTMENT

SCOPE OF WORK

PRINTING VARIOUS FORMS

1.0 PURPOSE

This specification establishes the minimum standard for printing, production and management of various forms for the City of Austin, Austin Police Department (APD), Health and Human Services, Emergency Medical Services and various other departments, herein after referred to as “City”. The successful bidder, hereinafter referred to as “Contractor” is required to meet all specifications listed herein as minimum requirements and is required to submit a firm fixed cost for all services under the terms of this solicitation. It is the intention of this specification to acquire complete printing, production and management of various forms any services that have been omitted from this specification which are clearly necessary or in conformance with normal printing, production and management practice shall be considered a requirement although not directly specified or called for in the specification.

2.0 BACKGROUND

On January II, 1990, Council approved a resolution known as the Comprehensive Recycling Resolution, which set goals for the purchase of recycled fine paper for City of Austin use. The Resolution establishes a policy to buy recycled fine paper so long as the price for recycled fine paper is no more that 10% higher than that for virgin paper.

In September 2013, the City Manager established the City of Austin Administrative Bulletin 13-03 regarding the Sustainable Printer and Paper Policy. The purpose of the Administrative Bulletin is to minimize the City’s printer and paper usage in order to reduce costs, save energy, and save natural resources. The primary goals of the Administrative Bulletin that relate to this solicitation are to purchase the most environmentally preferable paper products possible, and to reduce the quantity of paper used in city operations. The paper used for the City’s printing needs shall be environmentally preferable paper, including multi-function device paper, and any vendor printed items including stationary, business cards, stickers, etc. All paper should be made from 100% post-consumer content

3.0 TECHNICAL REQUIREMENTS

3.1 Contractor’s Minimum Qualifications & Experience

Contractor shall have at minimum three years’ experience in printing, production and management of forms.

3.2 Contractor’s Responsibilities

3.2.1 Contractor shall provide all labor, material and equipment required to print various forms as identified on Bid Sheet and Attachment 1.

3.2.2 Contractor shall use paper made from 100% post-consumer content.

3.2.3 If 100% post-consumer content is not available, paper used under this contract should be chlorine and acid free and forestry stewardship Council (FSC) Certified.

- 3.2.4 Contractor shall use grade 3 Standard Work: Most jobs are run under this category. Normal care and precision are exercised. While color match, register, and uniformity of inking through the run are important, extreme quality may be compromised in favor of cost. Goal is maximum quality at a competitive price.
- 3.2.5 Contractor may view samples of current form in attached PDF file. PDF File is not all inclusive and post award contracted vendor shall attain sample of form(s) required from each respective department prior to printing of any form.
- 3.2.6 Contractor shall obtain final proof approval from respective Department Contract Manager or designee prior to printing of sample of revised and/or new form(s).
- 3.2.7 Contractor shall not stock any of these forms.
- 3.2.8 Contractor shall shrink-wrap, box and/or pad forms in individual package as indicated on Bid Sheet unless otherwise specified at time of order.
- 3.2.9 Form content revision shall justify a one-time typesetting fee, but NOT a form price increase.
- 3.2.10 Form(s) similar to an existing form shall be priced at the same rate as forms listed on bid sheet based upon size/format/paper of same or similar current form.
- 3.2.11 Revision of existing form(s) that in addition to form content involve changes in construction, paper, number of copies, etc. will be subject to review by the Purchasing Office and a rate priced agreed on prior to printing the first order of the revised form. This price shall remain firm for the remainder of the contract period.
- 3.2.12 All proofs and negatives or artwork used in the production of forms shall remain the property of the City and shall be returned to the Contract Manager upon request at the end of the contract term.

3.3 *City's Responsibilities*

- 3.3.1 The City reserves the right to reject any printing deemed unsatisfactory by the respective Contract Manager or designee at no additional cost to the City.
- 3.3.2 The respective Contract Manager or designee will review typesetting fee and price will be determined prior to printing of the form(s).
- 3.3.3 Contract Manager or designee will place orders for reprinting of current forms or printing of new forms.
- 3.3.4 Contract Manager or designee will review and approve final proof prior to printing of form.

4.0 DELIVERY & ORDERING REQUIREMENTS:

- 4.1 Routine orders and deliveries shall be made within ten (10) business days of receipt of order, via fax or e-mail notification by Contract Manager or designee.
- 4.2 Rush delivery response shall be within twenty-four (24) hours of notification by department. The City estimates we will have approximately three (3) requests per year.
- 4.3 Vendor shall include one (1) copy of itemized packing slip to the delivery site; the following information shall be included on packing slips:
 - a. Contract Master Agreement Number,
 - b. Purchase Order Number (DO#),
 - c. City of Austin or Department stock number of each form.
 - d. Quantities ordered (in departments unit of issue),
 - e. Quantities shipped (in departments unit of issue),
 - f. Signature line for authorized department representative to sign for shipment.
- 4.4 Complete shipments are desired, however partial shipments shall be considered/required upon occasion, and shall be delivered at no additional cost to the City.
- 4.5 The City will not be responsible for payment on overages in printing and/or delivery of forms. Overages will not be allowed.
- 4.6 Deliveries shall be made to the existing following locations. The City reserves the right to add locations during the contract period, at no additional cost to the City.

APD Headquarters 715 E. 8th St. Austin, TX. 78701
 APD East-Sub 812 Springdale Rd. Austin, TX. 78702
 APD North-sub 12425 Lamplight Dr., Austin, TX. 78758
 APD South-sub 404 Ralph Ablanado Dr., Austin, TX. 78748
 Law Department 301 W. 2nd Street, Austin, TX 78701
 Aviation 9400 Freight Ln. Austin, TX 78719
 Health Department RBJ-15 Waller Street, 1st Floor, Austin, TX 78702
 Controller's Office 124 W. 8th St. Suite 140, Austin, TX 78701
 EHSD 1520 Rutherford Ln., Bldg. 1, Austin, TX 78754
 AFD Headquarters 4201 Ed Bluestein Blvd., Dock F, Austin, TX 78721
 EMS 4201 Ed Bluestein Blvd. Dock E, Austin, TX 78721

Estimated order quantities of each form are as noted on Bid Sheet and Attachment I including minimum order quantities if applicable.

- 4.7 Minimum order quantities are not allowed for this contract unless so stated in attachment 1. Any bid submitted stating minimum quantities will not be considered for award.

5.0 INVOICE REQUIREMENTS:

- 5.1 Invoice and one (1) signed packing slip copy shall be submitted to Department billing address as indicated below, for payment. Submitted packing slip for payment shall have an authorized representative signature. The City reserves the right to reject any unsigned packing slips.
- 5.2 Invoices shall be mailed to:

City of Austin- Police Department
Attn: Financial Management
P.O. BOX 1629
Austin TX. 78767-1629

City of Austin - Law Department
PO Box 1088
Austin, TX 78767

City of Austin - Aviation Department
3600 Presidential Blvd. Suite 411
Austin, TX 78719

Health Department
HHSD Accounting
PO Box 1088
Austin, TX 78767

City of Austin- Controller's Office
PO Box 2920
Austin, TX 78768

EHSD
PO Box 1088
Austin, TX 78767

City of Austin- Fire Department
Accounts Payable
4201 Ed Bluestein Blvd.
Austin, TX. 78721

AFD Accounts Payable e-mail FIREacctspayable@austintexas.gov

City of Austin- Emergency Medical Services
Attn: Accounts Payable
15 Waller St.
Austin, TX 78702

POLICE

ESCENA DEL CRIMEN
CRIME SCENE

**RESTRICTED
AREA**

AREA PROHIBIDO



**DO NOT
ENTER**

NO ENTRADA

FOR INFORMATION CONTACT: _____

INVESTIGATOR

DETAIL

TELEPHONE

ASSAULT VICTIM STATEMENT

Family & Dating Violence

I can read, write and understand the English language. This statement is true and correct to the best of my knowledge. I make this statement freely and voluntarily. Should I provide false information on this form, I understand that I could be prosecuted for the crime of "false report to a police officer" under section 37.08 of the Texas Penal Code. (Initials _____)

Date of this assault:	General Offense Number:	<input type="checkbox"/> Arrested	<input type="checkbox"/> On-Scene	<input type="checkbox"/> At Large
Time of Offense:	Where did the assault occur? (Address):			

Your Information	Full Name:	Race:	Sex:	Date of Birth:
	Address:		City/State/Zip:	
Home Phone:	Work Phone:	Cell Phone:	Pager:	

Suspect Information	Full Name:	Race:	Sex:	Date of Birth:
	Address:	City/State/Zip:	Probation <input type="checkbox"/> Parole <input type="checkbox"/>	
Place of Work/Address:				
Home Phone:	Work Phone:	Cell Phone:	Pager:	
Vehicle Info (Year/Color/Make/Model):				

Witness Information	Full Name:	Race:	Sex:	Date of Birth:
	Address:	Phone:		

Victim/Suspect Relationship	<input type="checkbox"/> Marriage (Legal)	Actions of the Suspect	<input type="checkbox"/> Striking	<input type="checkbox"/> Pulling	<input type="checkbox"/> Biting
	<input type="checkbox"/> Dating/Engaged ___ Yrs ___ Mnths		<input type="checkbox"/> Grabbing	<input type="checkbox"/> Strangling	<input type="checkbox"/> Suffocating
<input type="checkbox"/> Members of the Same Household		<input type="checkbox"/> Pushing	<input type="checkbox"/> Throwing	<input type="checkbox"/> Drugs/Alcohol	
<input type="checkbox"/> Former Members of the Household		<input type="checkbox"/> Threaten	<input type="checkbox"/> Other (Explain)		
<input type="checkbox"/> Biological Parents of Same Child		(Link action to injury – ie. Pushed on arm)			
<input type="checkbox"/> Blood Relation					
<input type="checkbox"/> Other _____					

Victim's Physical Condition	<input type="checkbox"/> Abrasion(s)	<input type="checkbox"/> Laceration(s)	What Suspect used to Injure or Threaten Victim:	<input type="checkbox"/> Hand	<input type="checkbox"/> Head	<input type="checkbox"/> Knife
	<input type="checkbox"/> Bruise(s) – New	<input type="checkbox"/> Loose Hair		<input type="checkbox"/> Foot	<input type="checkbox"/> Gun	<input type="checkbox"/> Other
<input type="checkbox"/> Bruise(s) – Old	<input type="checkbox"/> Bleeding		(Open Hand, fist, stick, rock etc.)			
<input type="checkbox"/> Swelling	<input type="checkbox"/> Complaint of Physical Pain					

Were you prohibited from making an emergency telephone call for assistance? Yes No

Do you want an Emergency Protective Order issued to the suspect? Yes No

Has the suspect ever hurt you before? ___ / If yes, Date(s) _____ Report Made? ___ Charges filed? ___

Describe the events leading up to the assault: _____

Victim's Signature _____

Date _____

Refused (Officer to Sign) _____

Witness _____

DECLARACIÓN DE LA VÍCTIMA

Violencia Familiar y Noviazgo

Puedo leer, escribir y entender el idioma Español. Esta declaración es correcta y verdadera según mi mejor conocimiento. Hago esta declaración de manera libre y voluntaria. Entiendo que si doy información falsa en esta forma, puedo ser enjuiciado(a) por el crimen de "reporte falso a un oficial de policía" bajo la sección 37.08 del Código Penal del Estado de Texas. (Iniciales _____)

Fecha de la agresión :	Número del incidente:	<input type="checkbox"/> Arrestado <input type="checkbox"/> En el Lugar <input type="checkbox"/> Prófugo
Hora del incidente:	¿Dónde ocurrió el ataque? (La Dirección)	

Su Información	Nombre Completo:	Raza:	Sexo:	Fecha de Nacimiento:
Dirección:		Ciudad/ Estado/ Código Postal:		
Teléfono de la casa:	Teléfono del trabajo:	Teléfono Celular:	Pager:	e-mail:

Información de los Testigos	Nombre Completo:	Fecha de Nacimiento:
Dirección:		Teléfono:

Información del Sospechoso(a)	Nombre Completo:	Raza:	Sexo:	Fecha de Nacimiento:
Dirección:		Ciudad/ Estado/ Código Postal:		

Lugar de trabajo/Dirección	Condena Probatoria <input type="checkbox"/>	Libertad Condicional <input type="checkbox"/>	
Teléfono de la casa:	Teléfono del trabajo:	Teléfono celular	Pager:

Información del vehículo (Año/ Color/ Marca/ Modelo):

Relacion entre Víctima y Sospechoso(a) *Marque todas las que apliquen	<input type="checkbox"/> Matrimonio (Legal)	Acciones del Sospechoso(a)	<input type="checkbox"/> Golpeó	<input type="checkbox"/> Jaló	<input type="checkbox"/> Mordió
	<input type="checkbox"/> Noviazgo/Compromiso __ años __ meses		<input type="checkbox"/> Agarró	<input type="checkbox"/> Estranguló	<input type="checkbox"/> Asfixió
<input type="checkbox"/> Miembros del mismo hogar	<input type="checkbox"/> Miembros del mismo hogar anteriormente	<input type="checkbox"/> Empujó	<input type="checkbox"/> Tiró	<input type="checkbox"/> Drogas/Alcohol	
<input type="checkbox"/> Padres biológicos del mismo hijo(a)	<input type="checkbox"/> Relación sanguínea	<input type="checkbox"/> Amenazó	<input type="checkbox"/> Otro (Explique)		
<input type="checkbox"/> Otro _____					Relacione la acción con la herida ej: Jaló el brazo

Condición Física de la Víctima	<input type="checkbox"/> Abrasión(es) (raspón)	<input type="checkbox"/> Cortada	Qué usó el Sospechoso(a) para herir o amenazar a la Víctima	<input type="checkbox"/> Mano	<input type="checkbox"/> Cabeza	<input type="checkbox"/> Cuchillo
	<input type="checkbox"/> Moretón(es)- Reciente(s)	<input type="checkbox"/> Cabello arrancado		<input type="checkbox"/> Pie	<input type="checkbox"/> Pistola	<input type="checkbox"/> Otro
<input type="checkbox"/> Moretón(es)- viejo	<input type="checkbox"/> Sangrado	<input type="checkbox"/> Queja de dolor físico		(Mano abierta, puño, palo, piedra, etc.)		
<input type="checkbox"/> Hinchazón						

Se le impidió a usted hacer una llamada telefónica de emergencia para pedir ayuda? Sí No

¿Quiere usted una Orden de Protección de Emergencia expedida al Sospechoso? Sí No

¿Le había lastimado antes el Sospechoso(a) ? _____ / si es sí, Fecha(s) _____ ¿

Se hizo un reporte? _____ ¿Se presentaron cargos? _____

En su opinión, ¿ "Anoté lo que ocurrió justo antes del ataque"? _____

Firma de la Víctima _____

Fecha _____

Rehusada (Refusal – Officer to sign) _____

Testigo (Witness) _____

Classification of Offense
(Check All Applicable)

- 3400 Family Disturbance
- 2400 Dating Disturbance

- (A) Assault with Injury
- (C) Assault by Contact/ Threat
- (B) Terroristic Threat
- (3) Assault with Injury Enhanced
- (3) Stalking
- (A) Viol of EPO/ Protective Order
- (3) Viol of EPO/ Prot. Order by Assault
- (2) Agg. Assault
- Injury to a Child/ Elderly/ Disabled
- Interfere w/ Emergency Telephone Call

MEDICAL TREATMENT

- None
- Will seek own doctor
- First Aid
- Paramedics
- Hospital
- Refused Medical Aid

If Transported:

Hospital: _____

Attending Physicians:

Victim Given:

- Domestic Violence Information Pamphlet
- General Offense Number
- Family Violence Prot. Team Phone Number

Paramedics at scene

- Yes
- No
- Unit Number: _____
- Name(s) & Employee #: _____

Did Crisis or Victim Services Respond? _____

ORIGIN/ CRIME DESCRIPTION

VICTIM

- Angry
- Apologetic
- Crying
- Fearful
- Hysterical
- Calm
- Afraid
- Irrational
- Threatening
- Complaint of pain
- Bruises
- Abrasion(s)
- Minor cut(s)
- Laceration(s)
- Fracture(s)
- Concussion(s)
- Nervous
- Other explain _____

SUSPECT

- Angry
- Apologetic
- Crying
- Fearful
- Hysterical
- Calm
- Afraid
- Irrational
- Threatening
- Complaint of pain
- Bruises
- Abrasion(s)
- Minor cut(s)
- Laceration(s)
- Fracture(s)
- Concussion(s)
- Nervous
- Other explain _____

EVIDENCE

Evidence Collected From:

- Crime Scene
- Hospital
- Other _____

911 Tape Requested Yes No

Photos: Yes No

No. of Photos: _____

- 35mm
- Polaroid
- Digital

Taken by: _____

Photos:

- Victim's Injuries
- Suspect's Injuries
- Weapon(s)

Type of Weapon(s) used:

Weapon(s) Seized: Yes No

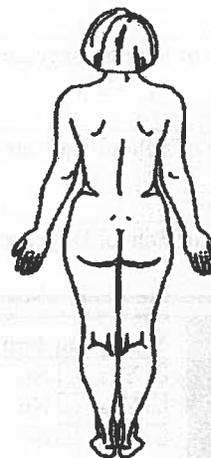
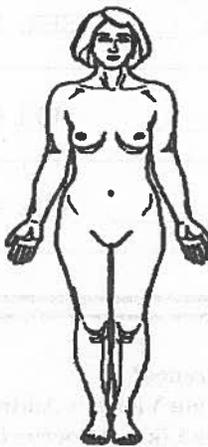
Draw on Diagram(s) the location of any injuries

Circle one

V S

HT _____

WT _____

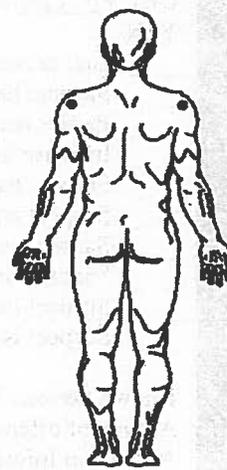
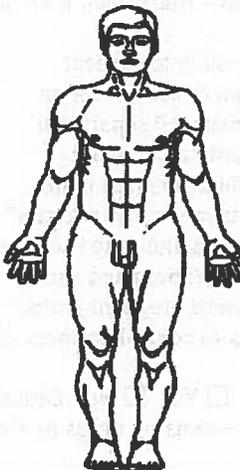


Circle one

V S

HT _____

WT _____



PROTECTIVE ORDERS: Yes No
 Current Expired

Type: Emergency Protective (EPO)
 Protective Order
 Ex-parte Temporary Protective Order

Issuing Court: _____ Order # _____

WEAPONS OWNED: _____

CONCEALED HANDGUN LICENSE: Yes No

24/ 48 Hour Hold Requested? Yes No (If so, 24 Hour 48 Hour)

Criteria pursuant to Article 17.291 of the Code of Criminal Procedure:
 Items 1-3 Pertain to 24 Hour Hold / Items 1-5 Pertain to 48 Hour Hold

- 1) The Defendant has been arrested or is being held without a warrant in a case involving family violence.
- 2) There is probable cause to believe that the violence will continue if the Defendant is immediately released.
- 3) Probable cause exists to believe the Defendant committed this family violence offense charged in this cause.
- 4) During the past 10 years, Defendant has been arrested for an offense involving family violence; and/or
- 5) During the past 10 years, Defendant used or exhibited a deadly weapon as defined by 1.07 of the Penal Code during the commission of an offense or during immediate flight after commission of an offense.

WITNESSES/ PROTECTED CHILD INFO

Witness(es) present during violence? Yes No Statements Taken? Yes No
 Children present during violence? Yes No
 Who is the primary caretaker of the children?: _____

- 1) Name: _____ DOB: _____ SEX: M or F
 Name of School/Daycare & Address: _____
- 2) Name: _____ DOB: _____ SEX: M or F
 Name of School/Daycare & Address: _____
- 3) Name: _____ DOB: _____ SEX: M or F
 Name of School/Daycare & Address: _____
- 4) Name: _____ DOB: _____ SEX: M or F
 Name of School/Daycare & Address: _____

FAMILY/DATING VIOLENCE RISK ASSESSMENT

History of Family Violence
 Yes No **First Time Occurrence?**
 Yes No **Prior 911 Calls from Victim's Address regarding this family?**
 Yes No **Is Family Violence Likely to occur in the foreseeable future?**

(Ask **VICTIM** to answer every item – Mark each item or Leave Blank if Not Applicable or Refused to Answer)

<u>Y</u> <u>N</u>	Gun present in home or accessible to suspect	<u>Y</u> <u>N</u>	Suspect abuses alcohol
---	Suspect has used or threatened to use a weapon	---	Suspect uses illegal/abuses legal drugs
---	Parties recently separated/threatened separation	---	Suspect violent outside of relationship
---	Increase in frequency or severity of violence	---	Suspect has accused victim of cheating
---	Suspect has destroyed cherished personal items	---	Suspect threatens to kill
---	Suspect has said, "If I can't have you, no one can"	---	Suspect violent towards children
---	Suspect contemplated/threatened/attempted suicide	---	Suspect has injured or killed pets
---	Victim contemplated/threatened/attempted suicide	---	Victim is currently pregnant
---	Suspect directed violence toward pregnant partner	---	Suspect has forced victim to have sex
---	Suspect is jealous or attempts to control partners daily activities		

Known Serious Mental Problems: Yes No Describe: _____
 At time of offense, had defendant been using drugs or alcohol? Yes No Unknown
 Additional Information: _____

AUSTIN POLICE DEPARTMENT - STRANGULATION SUPPLEMENT

TO BE COMPLETED IN ADDITION TO AVS

CASE # _____ - _____ DATE OF ASSAULT _____ TODAY'S DATE _____

VICTIM INFORMATION

TO BE COMPLETED BY POLICE OFFICER

Victim's Name (last, first, middle) _____ DOB _____ R/S ____ / ____

- ◆ Method and/or Manner (how was Victim strangled) One Hand - R One Hand - L Two Hands Forearm Knee/Foot
- Chokehold Other (explain) _____
- ◆ Is the Suspect right or left handed? Right Handed Left Handed
- ◆ Estimate how long you were strangled _____ Minute(s) _____ Second(s) Multiple times? Yes No
- Estimate Pressure Used (check) 1 2 3 4 5 6 7 8 9 10 (1=WEAK - 10=EXTREMELY STRONG)
- ◆ Suffocated? Yes No _____ Minute(s) _____ Second(s) What was used? _____
- ◆ What did Suspect say during strangulation/suffocation? _____
- ◆ Describe Suspect's demeanor during strangulation/suffocation? _____
- ◆ Describe how Suspect's face looked during strangulation/suffocation? _____
- ◆ What made Suspect stop? _____
- ◆ What did Victim think was going to happen during strangulation/suffocation? _____
- ◆ Has Suspect strangled/suffocated you before? Yes # _____ No

VICTIM'S SYMPTOMS

TO BE COMPLETED BY POLICE OFFICER

SYMPTOMS	DURING	AFTER	VOICE CHANGES	SWALLOWING CHANGES
unable to breathe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> painful to speak	<input type="checkbox"/> neck tenderness
difficult to breathe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> raspy/hoarse voice	<input type="checkbox"/> trouble swallowing
physical pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> coughing	<input type="checkbox"/> painful to swallow
rapid breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> unable to speak	<input type="checkbox"/> neck pain
shallow breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> whispering	<input type="checkbox"/> other _____
coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> other _____	
nausea	<input type="checkbox"/>	<input type="checkbox"/>		
vomiting/dry heaving	<input type="checkbox"/>	<input type="checkbox"/>		
dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Explain other _____	
headache	<input type="checkbox"/>	<input type="checkbox"/>	_____	
feel faint	<input type="checkbox"/>	<input type="checkbox"/>	_____	
disoriented	<input type="checkbox"/>	<input type="checkbox"/>	_____	

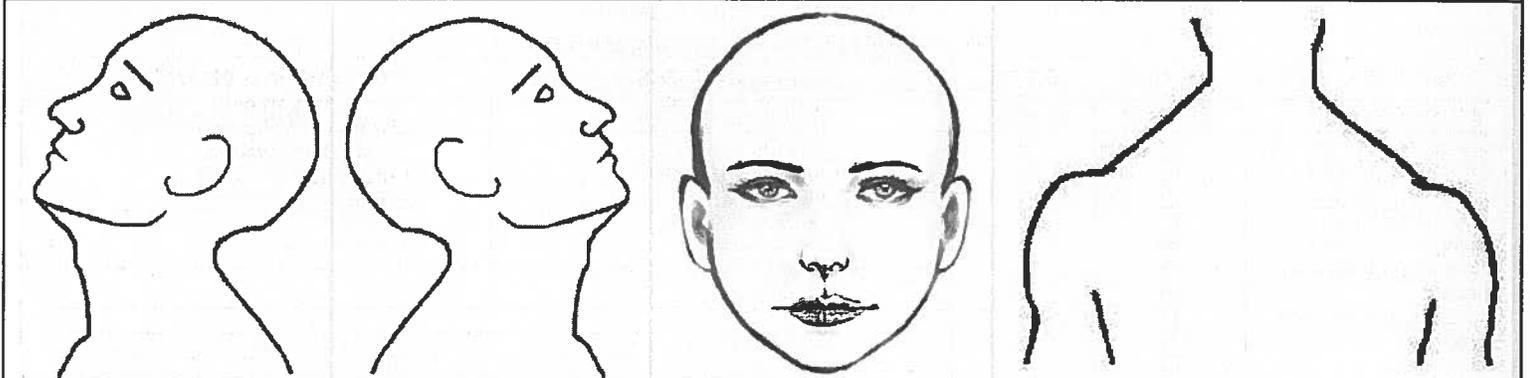
- ◆ Loss of consciousness? Yes No Victim not sure Unexplained Injury? Describe _____
- ◆ Any change or loss of hearing during/after strangulation/suffocation? Yes No Describe _____
- ◆ Any change or loss of vision during/after strangulation/suffocation? Yes No Describe _____
- ◆ How did your body/head feel during/after strangulation/suffocation? Describe _____
- ◆ Did the victim... Urinate Defecate Feel the urge to do one or both? _____

FACE	EYES AND EYELIDS	NOSE	EARS
<input type="checkbox"/> red or flushed	<input type="checkbox"/> petechiae to R eye	<input type="checkbox"/> petechiae	<input type="checkbox"/> petechiae on ear(s)
<input type="checkbox"/> petechiae	<input type="checkbox"/> petechiae to L eye	<input type="checkbox"/> scratch(es) or abrasion(s)	<input type="checkbox"/> bleeding from ear(s)
<input type="checkbox"/> scratch(es) or abrasion(s)	<input type="checkbox"/> petechiae to R eyelid	<input type="checkbox"/> swelling	<input type="checkbox"/> bruising/discoloration/ petechiae behind ear(s)
<input type="checkbox"/> sweating	<input type="checkbox"/> petechiae to L eyelid	<input type="checkbox"/> other _____	<input type="checkbox"/> swelling
<input type="checkbox"/> bruising	<input type="checkbox"/> blood in eyeball(s)		<input type="checkbox"/> other _____
<input type="checkbox"/> other _____	<input type="checkbox"/> other _____		
Explain other _____			

MOUTH	UNDER CHIN	CHEST	SHOULDERS
<input type="checkbox"/> bruise(s) <input type="checkbox"/> swollen tongue <input type="checkbox"/> swollen lip(s) <input type="checkbox"/> scratch(es)/abrasion(s) <input type="checkbox"/> other _____	<input type="checkbox"/> redness <input type="checkbox"/> scratch(es)/abrasion(s) <input type="checkbox"/> laceration(s) <input type="checkbox"/> bruise(s) <input type="checkbox"/> fingernail impression(s) <input type="checkbox"/> other _____	<input type="checkbox"/> redness <input type="checkbox"/> scratch(es)/abrasion(s) <input type="checkbox"/> laceration(s) <input type="checkbox"/> bruise(s) <input type="checkbox"/> other _____	<input type="checkbox"/> redness <input type="checkbox"/> scratch(es)/abrasion(s) <input type="checkbox"/> laceration(s) <input type="checkbox"/> bruise(s) <input type="checkbox"/> other _____

NECK	HEAD
<input type="checkbox"/> redness <input type="checkbox"/> tenderness/pain <input type="checkbox"/> finger mark(s) <input type="checkbox"/> scratch(es)/abrasion(s) <input type="checkbox"/> fingernail impression(s) <input type="checkbox"/> bruise(s) <input type="checkbox"/> ligature mark(s) <input type="checkbox"/> petechiae <input type="checkbox"/> swelling <input type="checkbox"/> other _____	<input type="checkbox"/> petechiae on scalp or head <input type="checkbox"/> laceration(s) <input type="checkbox"/> scratch(es)/abrasion(s) <input type="checkbox"/> hair pulled <input type="checkbox"/> bump(s) <input type="checkbox"/> other _____

*****PLEASE TAKE PHOTOGRAPHS*****
 Diagram all injuries on the Victim



Describe any other injuries or symptoms _____

OFFICER CHECKLIST

- If strangled/suffocated with object(s), photograph object(s) and collect for evidence.
- Document where the object(s) was/were found in the Offense Report.
- Determine if jewelry was worn by either party (ring(s), necklace(s), watch(es), etc.). Photograph / look for patterns and photograph.
- If defecation or urination in clothes, collect clothes as evidence.
- If Victim vomited, take a photo of vomit.
- Call On-Call Family Violence Detective if you need assistance.
- Call On-Call Family Violence Detective if Victim is transported to the hospital from injuries due to strangulation/suffocation.
- If Victim is transported to the hospital from injuries due to strangulation/suffocation then an officer **NEEDS** to standby at the hospital until the On-Call Family Violence Detective is notified.

STH/APD2013

VICTIM STATEMENT / DECLARACION DE LA VICTIMA

TO BE FILLED OUT BY VICTIM

I can read, write and understand the English Language. This statement is true and correct to the best of my knowledge. I make this statement freely and voluntarily. Should I provide false information on this form, I understand that I could be prosecuted for the crime of "False Report to a Police Officer" under section 37.08 of the Texas Penal Code. **Signature** _____ **Date** _____

Puedo leer, escribir y entender el idioma español. Esta declaración es verdadera y correcta en cuanto a lo que yo sepa. Hago esta declaración libre y voluntariamente. Si he dado información falsa en este formulario, entiendo que puedo ser enjuiciado por el crimen de "Declaración Falsa dada a un oficial de "Policía" bajo la sección 37.08 del Código Penal del Estado de Texas.

Firma _____ **Fecha** _____

♦ **Where are you right now?** _____ **Where did assault occur?** _____
¿Dónde se encuentra usted en este momento? _____ *¿Dónde ocurrió el asalto?* _____

♦ **Who assaulted you? (name/relationship)** _____
¿Quién asalto? (nombre/parentesco) _____

♦ **What led up to the assault?** _____
¿Qué ocurrió antes del asalto para que el asalto ocurriera? _____

♦ **How did Suspect assault you? (ex. hit w/ fist to head)** _____
¿Cómo le asaltó el/la sospechoso/a a usted (por ejemplo, le pegó con el puño en la cabeza) _____

♦ **What injuries do you have as a result of the assault?** _____
¿Qué lesiones tiene como resultado del asalto? _____

♦ **How did you get each injury?** _____
¿Cómo obtuvo cada herida? _____

♦ **Did you feel physical pain either at the time of the assault or after?** _____
¿Sintió usted dolor durante el asalto o después? _____

♦ **Was there damage to property (walls, phones, furniture, etc.)?** _____
¿Hubo daños a la propiedad (en las paredes, teléfonos, muebles, o en otros lugares)? _____

♦ **Other Information** _____
Otra información _____

Print Name - Nombre impreso _____

Signature _____ **Date** _____ **Time** ____ : ____ **am/pm**
Su firma _____ *Fecha* _____ *Hora* ____ : ____ *am/pm*

Officer Signature _____ **#** _____ **Date** _____ **Time** ____ : ____ **am/pm**
Firma del oficial _____ *#* _____ *Fecha* _____ *Hora* ____ : ____ *am/pm*

STH/APD2013

◆ Witness Information (May Use Witness Statement Form)

1. Name _____ DOB _____ R/S ___ / ___ Home#(___) _____
Work#(___) _____ Cell#(___) _____ Email Address _____
2. Name _____ DOB _____ R/S ___ / ___ Home#(___) _____
Work#(___) _____ Cell#(___) _____ Email Address _____

◆ Children Information (MUST list all children and document in narrative of offense report)

1. Present? Yes No Witness to assault? Yes No CPS Called? Yes No CPS# _____
Name of school child is attending _____
(If more than one child, then you MUST list all other information in your supplement report)

◆ Military Information

Victim in Military? Yes No Branch _____ Stationed _____
Suspect in Military? Yes No Branch _____ Stationed _____
Victim in Reserves? Yes No Texas National Guard Yes No
Suspect in Reserves? Yes No Texas National Guard Yes No

◆ Re-location/Contact Information

Are you planning to relocate? Yes No Address? _____
Phone#(___) _____ Cell#(___) _____ Other#(___) _____

**LETHALITY ASSESSMENT
TO BE COMPLETED BY A POLICE OFFICER**

"Yes" to ANY question 1-5, Activate or notify Victim Services

- 1. Has s/he ever threatened you with a weapon? Yes No NA
- 2. Has s/he used a weapon against you? Yes No NA
- 3. Has s/he ever threatened to kill you? Yes No NA
- 4. Has s/he ever threatened to kill your children? Yes No NA
- 5. Do you think s/he might try to kill you? Yes No NA

"Yes" to at least 4 questions 6-18, Activate or notify Victim Services

- 6. Does s/he have a gun? Yes No NA
- 7. Does s/he have easy access to a gun? Yes No NA
- 8. Has s/he ever tried to strangle you? Yes No NA
- 9. Is s/he violently or constantly jealous of you? Yes No NA
- 10. Does s/he control most of your daily activities? Yes No NA
- 11. Has s/he ever forced you to have sex when you did not wish to do so? Yes No NA
- 12. Have you ever left her/him or separated after living together? Yes No NA
- 13. Is s/he unemployed? Yes No NA
- 14. Has s/he ever tried to kill herself/himself? Yes No NA
- 15. Do you have a child that does not belong to the Suspect? Yes No NA
- 16. Does s/he follow you? Yes No NA
- 17. Does s/he spy on you? Yes No NA
- 18. Does s/he leave threatening messages? Yes No NA

◆ Describe the threat(s) and/or message(s) left _____

An Officer may request Victim Services(by phone or on-scene) as a result of Victim's response to the question below or whenever an officer feels it would be beneficial.

19. Is there anything else that worries you about your safety? Yes No NA
If yes, explain _____

- ◆ Victim Services responded due to High lethality determined by questions above Officer concerns for victim
- ◆ Victim Services did not respond due to Officer's decision Victim's request Victim Services' current call load
- ◆ Victim provided with Domestic Violence Information Pamphlet Yes No Case Number Yes No

TO COMPLETE AVS, GO TO PAGE 4.

AUSTIN POLICE DEPARTMENT - ASSAULT VICTIM STATEMENT

CASE # _____ - DATE OF ASSAULT _____ TODAY'S DATE _____

VICTIM INFORMATION TO BE COMPLETED BY POLICE OFFICER

Victim's Name (last, first, middle) _____ DOB _____ R/S ____ / ____
 Home Address _____ DL# _____ State _____ SSN# _____
 Home#(____) _____ Work#(____) _____ Cell#(____) _____ Place of Employment _____
 Email Address _____ Cell Provider _____ Pregnant? Yes No #Weeks _____
 Suspect's Name _____
 Does the suspect live at this address? Yes No If no... list address _____

◆ Emergency Contact(s)

(Person who can contact you at all times)
Contact 1 _____ (____) _____ (____) _____ (____) _____
 Name Address Home # Work # Cell #
Contact 2 _____

◆ Victim/Suspect Relationship

Dating/Engaged ____yrs. ____months Marriage -Legal ____yrs. ____months Member of Same Household Former Member of Same Household
Biological Parents of Same Child - # Children _____ Blood Relation Relationship Ended (date) _____

◆ Action(s) of Suspect

Striking (Open Hand Closed Hand) Pushing Throwing Grabbing Pulling Biting
Strangling/Suffocating (Complete Strangulation Supplement) Other (explain) _____

◆ How long has it been since the assault? _____ Hour(s) _____ Minute(s) _____ Day(s) _____

◆ Complaint of physical pain during or after the assault? Yes No Explain _____

◆ Did Suspect prevent you from making an emergency telephone call for assistance? Yes No How/Explain _____

◆ Did Suspect use or threaten to use a weapon against you? Yes No What type of weapon? _____
 How? _____

◆ Weapon(s) owned by Suspect? Yes No Does Suspect have Concealed Handgun License? Yes No
 List weapon(s) _____

◆ Did Suspect threaten you if you called the Police for this assault? Yes No Describe threat(s) _____

◆ Has Suspect hurt you before? Yes No Date? _____ Where? _____ Frequency? _____
 How? _____

◆ Was a report made? Yes No To whom? _____

◆ Has Suspect ever threatened you if you called the Police? Yes No Describe threat(s) _____

◆ Has Suspect ever harmed or threatened to harm the children? Yes No How? _____

◆ Has Suspect ever harmed or threatened to harm the household pets? Yes No How? _____

◆ Was a report made? Yes No To whom/Which agency? _____

◆ Was Suspect using drugs at the time of this assault? Yes No What? _____

◆ Does Suspect use the following? Alcohol Prescription Medication - What? _____
Illegal Drug(s) - What? _____ Other - Describe _____

◆ Do you want an Emergency Protective Order? Yes No

◆ Do you have a Protective Order? Yes No # _____ Expiration Date _____

VICTIM DESCRIPTION TO BE COMPLETED BY POLICE OFFICER

DEMEANOR	PHYSICAL CONDITION	APPEARANCE	SPEECH
<input type="checkbox"/> afraid <input type="checkbox"/> hysterical	<input type="checkbox"/> abrasion(s) <input type="checkbox"/> laceration(s)	<input type="checkbox"/> bloody clothes	<input type="checkbox"/> angry
<input type="checkbox"/> angry <input type="checkbox"/> indifferent	<input type="checkbox"/> bruise(s) new <input type="checkbox"/> loose hair	<input type="checkbox"/> smeared makeup	<input type="checkbox"/> out of breath
<input type="checkbox"/> apologetic <input type="checkbox"/> intoxicated	<input type="checkbox"/> bruise(s) old <input type="checkbox"/> shaking	<input type="checkbox"/> soiled/sweat stained	<input type="checkbox"/> excited/fast
<input type="checkbox"/> belligerent <input type="checkbox"/> irrational	<input type="checkbox"/> bleeding <input type="checkbox"/> redness	<input type="checkbox"/> tangled/messy hair	<input type="checkbox"/> crying/sobbing
<input type="checkbox"/> calm <input type="checkbox"/> nervous	<input type="checkbox"/> physical pain <input type="checkbox"/> swelling	<input type="checkbox"/> torn/pulled clothing	<input type="checkbox"/> yelling
<input type="checkbox"/> crying <input type="checkbox"/> fearful	<input type="checkbox"/> fracture(s) <input type="checkbox"/> other _____	<input type="checkbox"/> other _____	<input type="checkbox"/> belligerent
<input type="checkbox"/> distraught <input type="checkbox"/> other _____	<input type="checkbox"/> sweating		<input type="checkbox"/> other _____
Explain other _____			

WHAT SUSPECT USED TO HURT /THREATEN VICTIM		CRIME SCENE OBSERVATIONS
<input type="checkbox"/> Hand <input type="checkbox"/> Head <input type="checkbox"/> Foot <input type="checkbox"/> Knife <input type="checkbox"/> Gun <input type="checkbox"/> Other _____		<input type="checkbox"/> Signs of Disturbance <input type="checkbox"/> Clump(s) of Hair <input type="checkbox"/> Broken Furniture <input type="checkbox"/> Blood at Scene <input type="checkbox"/> Broken Phone <input type="checkbox"/> Hole(s) in Wall <input type="checkbox"/> Broken Glass <input type="checkbox"/> Children Crying <input type="checkbox"/> Weapon(s) <input type="checkbox"/> Phone Cord Yanked <input type="checkbox"/> Other _____
Weapon Seized? <input type="checkbox"/> Yes <input type="checkbox"/> No	Photos Taken? <input type="checkbox"/> Yes <input type="checkbox"/> No # Taken _____ By # _____ <input type="checkbox"/> Victim <input type="checkbox"/> Suspect <input type="checkbox"/> Injury <input type="checkbox"/> Location of Pain <input type="checkbox"/> Weapon(s) <input type="checkbox"/> Crime Scene	
Evidence Collected? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Turned into PCO		

◆ **Medical Treatment**

Basic First Aid/Not Transported Treated By _____ EMT Name/# _____

Transported Where _____ Address _____ City _____ State _____

Will Seek Own Physician Physician's Name _____ Address _____ City _____

Will Get Treatment at Clinic Clinic's Name _____ Address _____ City _____

Refused

None

SUSPECT INFORMATION
TO BE COMPLETED BY POLICE OFFICER

Suspect's Name (last, first, middle) _____ DOB _____ R/S ____ / ____

Home Address _____ DL# _____ State _____ SSN# _____

Home#(____) _____ Work#(____) _____ Cell#(____) _____ Place of Employment _____

Email Address _____ Cell Provider _____ Pregnant? Yes No #Weeks _____

Suspect Arrested Not at Scene Photo Available Yes-Taken No Scars/Tattoos No Yes If yes...describe _____

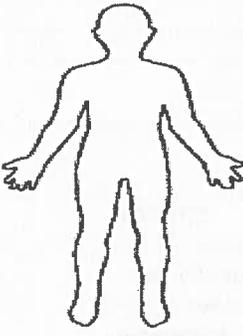
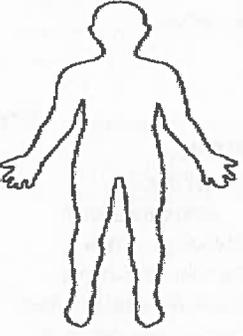
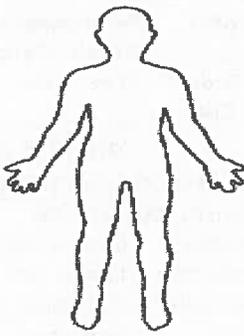
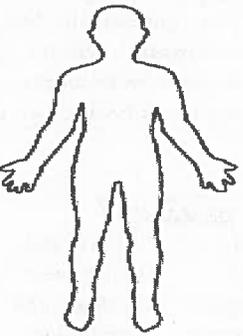
SUSPECT DESCRIPTION
TO BE COMPLETED BY POLICE OFFICER

DEMEANOR	PHYSICAL CONDITION	APPEARANCE	SPEECH
<input type="checkbox"/> afraid <input type="checkbox"/> hysterical	<input type="checkbox"/> abrasion(s) <input type="checkbox"/> laceration(s)	<input type="checkbox"/> bloody clothes	<input type="checkbox"/> angry
<input type="checkbox"/> angry <input type="checkbox"/> indifferent	<input type="checkbox"/> bruise(s) new <input type="checkbox"/> loose hair	<input type="checkbox"/> smearred makeup	<input type="checkbox"/> out of breath
<input type="checkbox"/> apologetic <input type="checkbox"/> intoxicated	<input type="checkbox"/> bruise(s) old <input type="checkbox"/> shaking	<input type="checkbox"/> soiled/sweat stained	<input type="checkbox"/> excited/fast
<input type="checkbox"/> belligerent <input type="checkbox"/> irrational	<input type="checkbox"/> bleeding <input type="checkbox"/> redness	<input type="checkbox"/> tangled/messy hair	<input type="checkbox"/> crying/sobbing
<input type="checkbox"/> calm <input type="checkbox"/> nervous	<input type="checkbox"/> physical pain <input type="checkbox"/> swelling	<input type="checkbox"/> torn/pulled clothing	<input type="checkbox"/> yelling
<input type="checkbox"/> crying <input type="checkbox"/> fearful	<input type="checkbox"/> fracture(s) <input type="checkbox"/> other _____	<input type="checkbox"/> other _____	<input type="checkbox"/> belligerent
<input type="checkbox"/> distracted <input type="checkbox"/> other _____	<input type="checkbox"/> sweating		<input type="checkbox"/> other _____

Explain other _____

BODY INJURY DIAGRAM
TO BE COMPLETED BY POLICE OFFICER

Mark all injuries on both the Victim and the Suspect

HT _____ WT _____ SEX _____ VICTIM  FRONT	 BACK	HT _____ WT _____ SEX _____ SUSPECT  FRONT	 BACK
--	--	---	--

Describe injuries and how each was inflicted in the narrative of the offense report.

EVIDENCE

CHAIN OF CUSTODY

IMPOUNDING OFFICER	DATE	TIME
--------------------	------	------

1.

RELEASED TO	RELEASED BY	DATE	TIME
-------------	-------------	------	------

2.

3.

4.

5.

6.

7.

8.

9.

10.

11.

(PD-0015)

S.S. NO.

HT.

WT.

BIRTH
DATE

OCC

ADD

PRINTED BY

DATE

OFFENSE # _____

ORGN CODE:

--	--	--	--

LOCATION CODE:

F					
----------	--	--	--	--	--

**AUSTIN POLICE DEPARTMENT
OVERTIME/COMPENSATORY
ASSIGNMENT FORM**

WO#

8	7						
----------	----------	--	--	--	--	--	--

Incomplete overtime forms will be returned & result in delay in payment.
OVERTIME ONLY

DATE WORKED: _____ HOURS WORKED FROM: _____ TO: _____ REGULAR FROM: _____ TO: _____
DUTY HOURS TO: _____

REASON FOR ASSIGNMENT: _____

COURT ASSIGNMENT: _____ DEFENDANT'S NAME: _____

PRINT NAME CLEARLY OF ASSIGNED EMPLOYEE (NO Nicknames)	CITY EMP. #	APD EMP. #	HOURS WORKED	EMPLOYEE INITIALS
LAST FIRST NAME				
1. _____				
2. _____				
3. _____				
4. _____				
5. _____				
6. _____				

DATE RECEIVED: _____ APPROVING SUPERVISOR: _____ APP. DIV COMMANDER: _____

COMP TIME ONLY

DATE WORKED: _____ HOURS WORKED FROM: _____ TO: _____ REGULAR FROM: _____ TO: _____
DUTY HOURS TO: _____

REASON FOR ASSIGNMENT: _____

COURT ASSIGNMENT: _____ DEFENDANT'S NAME: _____

PRINT NAME CLEARLY OF ASSIGNED EMPLOYEE (NO Nicknames)	CITY EMP. #	APD EMP. #	HOURS WORKED	EMPLOYEE INITIALS
LAST FIRST NAME				
1. _____				
2. _____				
3. _____				
4. _____				
5. _____				
6. _____				

DATE RECEIVED: _____ APPROVING SUPERVISOR: _____ APP. DIV COMMANDER: _____

DATE POSTED:

--	--	--	--	--	--

FOR OFFICE USE ONLY
STAFF INITIAL:

--	--	--	--	--	--

ROUTING
WHITE COPY- Personnel
PINK COPY- Employee

**OVERTIME / COMPENSATORY
(Please Circle)
ASSIGNMENT FORM**

DATE WORKED: _____
(Attach to Page 1 for Overtime/
Comptime Processing)

ORGN # _____
PAGE # _____
OFFENSE # _____
W.O. # _____

PRINT NAME CLEARLY OF ASSIGNED EMPLOYEE			SOCIAL SECURITY #	EMP NO.	HOURS WORKED	PAYMENT OT. or CT.	EMPLOYEE INITIALS
LAST	FIRST	NAME					
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							
16.							
17.							
18.							
19.							
20.							
DATE RECEIVED:			APPROVING SUPERVISOR:	APP. DIV COMMANDER:			

DATE POSTED:

FOR OFFICE USE ONLY
STAFF INITIAL:

ROUTING:
WHITE COPY--Personnel
PINK COPY--Employee

CRIMINAL TRESPASS: **NOTICE** (ORIGINAL REPORT) **ARREST** (SUPPLEMENT) **REPORT** (SUPPLEMENT with AFFIDAVIT)

GENERAL (2716) **HOTEL (2722)** **TRANSIENT (2721)**

ORIGINAL INCIDENT NUMBER	DATE	TIME	SECTOR
		AM PM	

TRESPASS LOCATION	BUSINESS NAME OR PROPERTY OWNER	(IF A BUSINESS)
		OPEN CLOSED

SUBJECT INFORMATION:

LAST NAME	FIRST NAME	MIDDLE NAME	DATE OF BIRTH

RACE / SEX	HEIGHT	WEIGHT	HAIR	EYES	IDENTIFICATION NUMBER	STATE	TYPE

HOME ADDRESS	CITY	STATE	ZIP CODE

EMPLOYER OR WORK ADDRESS	WORK PHONE	CELL PHONE /PAGER	HOME PHONE

VEHICLE INFORMATION:

YEAR	COLOR	MAKE	MODEL	STYLE	STATE	LICENSE NUMBER OR V.I.N.

THE SECTION BELOW IS COMPLETED FOR [NOTICES] ONLY.

YOU, _____, ARE HEREBY NOTIFIED TO IMMEDIATELY LEAVE THESE PREMISES AND ARE PROHIBITED FROM COMING ON THE PROPERTY OR PREMISES OF: _____ FOR ANY REASON AT ALL. IF YOU ARE FOUND ON THIS PROPERTY, OR REMAIN ON THIS PROPERTY AFTER THIS NOTICE, YOU WILL BE ARRESTED FOR THE OFFENSE OF:

- CRIMINAL TRESPASS -

THE SECTION BELOW IS COMPLETED FOR [NOTICES] ONLY.

I, _____, THE UNDERSIGNED, UNDERSTAND THIS NOTICE IS EFFECTIVE IMMEDIATELY. I FURTHER UNDERSTAND THAT THE ABOVE NOTICE MAY BE RESCINDED ONLY BY WRITTEN NOTIFICATION. I ALSO UNDERSTAND THAT IF I REFUSE TO SIGN THIS NOTICE ** IT IS STILL EFFECTIVE.

X _____		
SIGNATURE OF INDIVIDUAL RECEIVING NOTICE	POLICE OFFICER WITNESSING THIS NOTICE	EMPLOYEE #

PROPERTY OWNER () OR OWNER'S CONTROLLING AGENT ()	ENTER ISSUING AUTHORITY INFORMATION BELOW:		
LAST NAME	FIRST NAME	R/S	DATE OF BIRTH
			TYPE/IDENTIFICATION #

NARRATIVE / CALL INFORMATION

(APD NARRATIVE ON WHITE COPY ONLY):

SUBJECT'S SIGNATURE

SUBJECT'S STREET ADDRESS

PHONE NUMBER

BIRTH DATE

SOCIAL SECURITY NUMBER

PALM PRINTS

IDENTIFICATION SECTION - AUSTIN POLICE DEPARTMENT

SUBJECT'S NAME

DATE TAKEN

TAKEN BY (SIGN)

A.P.D. NO.

#

RIGHT PALM (OVER For LEFT Palm)

**RIGHT PALM
(OVER For LEFT Palm)**

IDS-5 PD 0042

APD CASE DISPOSITION SHEET

APD Numb. _____
DPS Numb. _____
FBI Numb. _____
(ID SECTION COMPLETE)

APD OFFENSE #. _____
OFFENSE DATE _____
DA CONTROL #. _____
C.A. CONTROL #. _____
Municipal Court CAUSE #. (Class C) _____

Arresting Officer _____ Emp. # _____ Unit ID _____

Location of Offense: _____ Austin, TX. County: [Travis] [Williamson]

Area Command of Incident Location (Circle One):

NW NE CW (Baker 1 or Baker 2) CE SW SE Other (specify) _____

Charge Filed: _____

Felony: Capital ____ 1st degree ____ 2nd degree ____ 3rd degree ____ State Jail ____

Misdemeanor: Class "A" ____ Class "B" ____ Class "C" ____

Defendant: _____	Race: _____	Sex: _____
DOB _____	LAST _____	FIRST _____
City: _____	State: _____	Phone #: _____
Residence Address: _____	M.I. _____	

Prosecutor's Section

Cause #: _____ Trial: [] By Jury [] No Jury [] Guilty [] Not Guilty

Charge Reduced: [] Yes [] No If yes, reduced to: _____

Punishment: [] Jail [] Prison Time: _____ [] Days [] Months [] Years Fine: _____

Court Costs: \$ _____ Restitution: \$ _____ Community Service Hours: _____

Probation: _____ [] Months [] Years Deferred Adjudication: _____ [] Months [] Years

Conditional Discharge: _____ [] Months [] Years

Was sentence a result of plea-bargaining? [] Yes [] No [] No Billed by Grand Jury

Dismissed for following reason(s):

- | | |
|---|--|
| <input type="checkbox"/> Request of Victim | <input type="checkbox"/> Police Officer Failed to Appear |
| <input type="checkbox"/> Lack of Evidence | <input type="checkbox"/> Other Witness Failed to Appear |
| <input type="checkbox"/> At Examining Trial | <input type="checkbox"/> PC 12.45 |
| <input type="checkbox"/> Convicted on Other Charges | <input type="checkbox"/> Made Restitution |
| <input type="checkbox"/> Speedy Trial Act | <input type="checkbox"/> Other Dismissal |

Prosecutor Remarks: _____

Disposition Date: _____ County Court #: _____ Prosecutor: _____ Judge: _____

APD Section

Routing Instructions:

YELLOW Copy: Investigative Unit
WHITE Copy: Fugitive Unit/Identification Section
PINK Copy: Arresting Officer

JUVENILE ARREST CARD

Travis County

IS THE IDENTITY OF YOUR PRISONER IN QUESTION? Y N

DO YOU HAVE A POSITIVE ID AVAILABLE? Y N

NAME (Last, First, Middle)								TRN
AKA / Maiden Name / Nickname								JID
Sex	Race	Eth	Height	Weight	DOB	Place of Birth	Citz	DPS #
Hair	Eyes	Skin Tone Complexion		Build			FBI #	
Address			City	State	Zip	Phone #		SS #
Mailing Address (if different than St. Add.)				City	State	Zip		DL
School				Grade	Location (city)			ID State Type
During School Hours Y N	School Notified Y N	Parents Notified Y N	By			MISC #		
Father's Name				Home Phone				Gang Information
Address			City	State	Zip			
Employer			Work Phone					
Mother's Name				Home Phone				Scars/Marks/Tattoos
Address			City	State	Zip			
Employer			Work Phone					
Medical Information Drug Use Information (Paint/Speed/Glue/Etc.)								
Date of Arrest		Time		Officer Name			Emp #	Agency
Arrest Location				City			State	
Transporting Officer		Emp #		Releasing Officer		Emp #		Firearm Code
1	Offense (Charge)			Offense Date			Degree/Level	
	Cause/Warrant #		Offense #		Referral Date/Time			
2	Offense (Charge)			Offense Date			Degree/Level	
	Cause/Warrant #		Offense #		Referral Date/Time			
3	Offense (Charge)			Offense Date			Degree/Level	
	Cause/Warrant #		Offense #		Referral Date/Time			
4	Offense (Charge)			Offense Date			Degree/Level	
	Cause/Warrant #		Offense #		Referral Date/Time			
5	Offense (Charge)			Offense Date			Degree/Level	
	Cause/Warrant #		Offense #		Referral Date/Time			
Facts of Arrest:								
Was the victim informed of their rights? Y N								Right Index Print
ONE OR MORE OF THE FOLLOWING MUST BE CHECKED:				Signature of Parent/Guardian				
<input type="checkbox"/> Was treated by EMS and/or Branch prior to booking. <input type="checkbox"/> Has medical problems and/or injuries. <input type="checkbox"/> Refused all medical treatment prior to booking. <input type="checkbox"/> Intermediate level (or higher) weapon(s) were applied. <input type="checkbox"/> None of the above				Released to:				

PROPERTY		TOT. CASH	NO. OF CHKS.	RARE COINS	MEDICATION
			TOTAL		
ALOHOLIC BEV.	KEYS	OTHER PROPERTY OR INFORMATION		EVIDENCE	DISPOSITION - OFFICER PLACING IN PROPERTY ROOM
ANIMAL	KNIIFE				
BACK PACK	LIGHTER				
BELT	MEDICATION				
BILLFOLD	NECKLACE				
BRACELET	PENCILS - PENS				
CHECK BOOK	KEYS				
COAT	PURSE				
COIN PURSE	RINGS				
COMB	SHOELACES				
DRIVER'S LIC.	SUITCASE				
EARRINGS	WATCH				
GLASSES	WIG				
HAT					
VEHICLE INFO. (BIKE, CAR, ETC.)			PROPERTY TRANSFERRED WITH JUVENILE		
YEAR MAKE MODEL		YES	NO		
SIGNATURE OF PERSON PROPERTY RELEASED TO		SIGNATURE OF PARENT OR GUARDIAN JUVENILE RELEASED TO		SREFERRAL AGENCY (PROJECT CONNECT, ETC.) YES <input type="checkbox"/> NO <input type="checkbox"/>	
COLOR LIC. NO.					
DISPOSITION				COUNSELOR'S NAME	



APD WRECKER/IMPOUND REPORT

Offense Number _____ DATE & Time Notified: _____ Time Arrived: _____ Time Cleared _____

POLICE ACTION

___ IMPOUND ___ ROTATION ___ REQUEST ___ MOVED ___ HOLD ___ DETAIL

Reason for Tow: _____ If Hold (name and emp # approving) _____

Wrecker Type ___ Category A ___ Category B ___ Category C ___ Zone Rush Hour

REQUEST WRECKER: Name of Person/Driver Making Request: _____

OFFICER NOTES: _____

Vehicle Pick up Location: _____

Vehicle Drop Location: (if other than VSF) _____

VEHICLE INFORMATION:

YEAR ___ MAKE ___ MODEL ___ TYPE ___ COLOR _____

LICENSE: _____ STATE ___ VIN _____

Driver: _____ Address: _____

Owner: _____ Address: _____

Vehicle damage prior to tow: _____

Vehicle damaged during tow: _____

VEHICLE INVENTORY: _____

(Inventory of valuable property visible inside vehicle's passenger compartment.)

TOWING COMPANY DISPOSITION:

Towing Company/Wrecker Business name: _____

Address: _____ Phone No. _____

VSF Location Vehicle Stored: _____

Wrecker category Fee: \$ _____ Additional Charges: \$ _____ Wait Time /Extra Labor: \$ _____

List additional items above: _____ TOTAL: \$ _____

(The above charges do not include Storage Fees or other Fees allowed by State Law)

Signature of Wrecker Driver: _____ Printed Name: _____

Signature of Driver/Owner: _____

Police Officer/Employee #: _____

Impound Routing:	white copy - Data entry	Crash routing:	white copy - File w/ crash report
	canary - Detail w/hold		canary - Vehicle Storage Facility
	pink copy- Wrecker Driver/Company		pink copy- Wrecker Driver/Company
	goldenrod - Vehicle Owner		goldenrod - Vehicle Owner



Enforcement of City of Austin Towing Ordinance violations are accomplished by issuing Traffic Citations for the following non-consent towing violations.

- Violation Wrecker Ord- Wrecker exceeding 45 minute response time (does not include impounds)
- Violation Wrecker Ord- No City Tow Truck Operator License while performing non-consent tow
- Violation Wrecker Ord- Failed to wear Tow Truck Operator License (non-consent)
- Violation Wrecker Ord- Failed to release vehicle within 1 hour from VSF
- Violation Wrecker Ord- Solicited Wrecker Business at crash scene (does not include zone)
- Violation Wrecker Ord- Failed to remove debris
- Violation Wrecker Ord- No or Expired City Inspection Certificate while performing non consent tow
- Violation Wrecker Ord- Failed to notify Austin Police Department within required time
- Violation Wrecker Ord- Failed to carry required equipment

Note: Issues related to Police Impounds are governed by the Impound contract.

13-6-4 DEFINITIONS.

In this chapter:

- (1) CONSENT TOW means a tow of a motor vehicle initiated by the owner or operator of the vehicle or by a person who has possession, custody, or control of the vehicle. The term does not include a tow of a motor vehicle initiated by a peace officer investigating a traffic accident or a traffic incident that involves the vehicle.
- (4) NON-CONSENT TOW means a tow that is not a consent tow

City of Austin Non Consent Towing Fees

Category A Wrecker	(vehicles weighing 10,000lbs or less)	\$150.00
Category B Wrecker	(vehicles in excess of 10,000lbs but less than 26,000lbs)	\$400.00
	A&B Exceptional labor such as clearing debris	\$35.00 per hour
	A&B Winching, one-hour minimum, only if normal hook-up is not possible because of conditions or location of vehicle:	\$35.00 per hour
	A&B Wait time: if it exceeds 30 minutes from time of arrival at accident scene.	\$15.00 per hour
Category C Wrecker	(vehicles in excess of 26,000lbs)	\$800.00
	Work time (Winching, preparing vehicle to be towed, and wait time):	\$25.00 per ¼ hour
	Exceptional labor (manpower):	\$15.00 per hour per man
	Additional Category C tow truck:	\$800.00
	Additional specialized equipment:	\$300.00 per hour
	Air bags	\$100.00 per bag per hour
	Fork lift	\$125.00 per hour.
	Haul trailers	\$500.00
	Trailer dollies (Used to move semi-trailers)	\$300.00
	Wait time:	\$20.00 per hour
	Large slide trucks/rollbacks	\$200.00 maximum
	(3 ton minimum size for hauling vehicles or equipment with gross weight 15,000 pounds or more)	

Vehicle storage fees are regulated by state law: Once towed to a Vehicle Storage facility, additional fees will apply, for complete details on storage fees and other towing information see the Texas Department of Transportation Web site at www.dot.state.tx.us/mcd/towing/storage.htm for information.

For additional information contact the Austin Police Department Wrecker Enforcement Vehicle Abatement Unit at (512) 974-8110 or Wrecker.Enforcement@ci.austin.tx.us

LEAVE REQUEST		AUSTIN POLICE DEPARTMENT	
NAME	EMP. NO.	DIVISION	REGULAR DAYS OFF
		TITLE	REGULAR DUTY HOURS
REQUEST SHOULD BE USED FOR: 1. VACATION LEAVE 2. PERSONAL HOLIDAY 3. COMP. LEAVE 4. EMERGENCY LEAVE (SHOW FAMILY MEMBER ATTENDING) 5. MILITARY LEAVE 6. LEAVE OF ABSENCE 7. LEAVE WITHOUT PAY 8. EXCEPTION VACATION	TYPE OF REQUEST:		TOTAL HOURS REQUESTED:
	ACTUAL DATES (OR HOURS) OF TIME OFF:		
AVAILABLE FOR COURT <input type="checkbox"/> YES <input type="checkbox"/> NO		CAN BE REACHED AT ADDRESS	
		PHONE:	
EXPLANATION REQUIRED FOR: SICK LEAVE; EMERGENCY LEAVE; LEAVE OF ABSENCE OR LEAVE WITHOUT PAY		REQUESTORS SIGNATURE	
		DATE AND TIME REQUEST RECEIVED	
		APPROVED BY	
		APPROVED BY	

UNDERCOVER EXPENSE REPORT

AUSTIN POLICE DEPARTMENT

(1) ASSIGNED UNIT	(2) OFFENSE #
(3) EXPENSE TYPE Evidence Purchase ___ Misc. Expense ___ Narcotics Purchase ___ Paid to C.I. ___ Other _____	(4) DATE
(7) DESCRIPTION OF EXPENSE ----- ----- ----- -----	(5) RADIO CALL SIGN
(9) SUPERVISOR'S SIGNATURE	(6) PRINT NAME & EMP. #
(11) SIGNATURE OF WITNESS	(8) SLIP #
(10) SIGNATURE OF REPORTEE	

POLICE NOTICE of ABANDONED MOTOR VEHICLE

This vehicle is an Abandoned Motor Vehicle in violation of Chapter 9-1 of the City Code of Austin

1. This Abandoned Motor Vehicle must be removed within 48 hours from the time of this notice. After that time, it will be impounded.
2. The term "Abandoned Motor Vehicle" means a motor vehicle that:
 - A. Is inoperable, is more than 5 years old, and has been left unattended on public property for more than 48 hours;
 - B. Has remained illegally on public property for more than 48 hours;
 - C. Has remained on private property without the consent of the owner or person in charge of the property for more than 48 hours;
 - D. Has been left unattended on the right of way of a designated county, state, or federal highway for more than 48 hours; or
 - E. Has been left unattended for more than 24 hours on the right-of-way of a controlled access highway.

The City may abate a nuisance, take custody of a vehicle, and dispose of a vehicle as provided in Chapter 683 of the Texas Transportation Code.

For more information 974-8119

Chief of Police

DEPARTAMENTO DEL POLICÍA - CIUDAD DE AUSTIN

AVISO del POLICÍA del VEHÍCULO de MOTOR ABANDONADO

Este vehículo es un vehículo de motor abandonado en la violación del capítulo 9-1 del código municipal de la ciudad de Austin

1. Este vehículo de motor abandonado se debe quitar en el plazo de 48 horas a partir recibir de este aviso. Después de ese tiempo, será confiscado.
2. El término "vehículo de motor abandonado" significa un vehículo de motor eso:
 - A. Son inoperables, son más de 5 años de viejo, y se ha dejado desatendido en una propiedad pública por más de 48 horas;
 - B. Ha permanecido ilegal en una propiedad pública por más de 48 horas;
 - C. Ha permanecido en propiedad privada sin el consentimiento del dueño o de la persona a cargo de la propiedad por más de 48 horas;
 - D. Ha sido desatendido en la derecha de la manera de un condado señalado, de un estado, o de una carretera federal por más de 48 horas; o
 - E. Ha sido desatendido por más de 24 horas en el derecho de paso de una carretera controlada del acceso.

La ciudad puede disminuir un fastidio, tomar custodia de un vehículo y disponer de un vehículo en la manera prevista en el capítulo 683 del código del transporte de Tejas.

Para más información 974-8119

Jefe del Policia

Employee/Empleado _____ Emp.# _____

Date affixed/Fecha puesta _____ Time/Hora _____

**POLICE NOTICE
ABANDONED NON – MOTORIZED VEHICLE**

This vehicle is a Non – Motorized Vehicle in violation of Chapter 12-5 of the City Code of Austin

1. This Non – Motorized Vehicle must be removed within 48 hours from the time of this notice. After that time, it will be deemed abandoned and will be impounded.
2. The term “Abandoned Property” means personal property, other than a motor vehicle, that is left unattended in a public place:
 - A. In violation of law;
 - B. For more than 48 hours; or
 - C. In a manner that interferes with vehicular or pedestrian traffic.

The City may remove abandoned property to a place of impoundment designated by the City Manager, and may dispose of the property as provided in Chapter 9-1 of the City Code of Austin.

For more information 974-8119

Chief of Police

DEPARTAMENTO DEL POLICÍA - CIUDAD DE AUSTIN

**AVISO DEL POLICÍA
VEHÍCULO ABANDONADO NON-MOTORIZED**

Este vehículo es un vehículo abandonado no motorizado en la violación del capítulo 12-5 del código municipal de la ciudad de Austin

1. Este vehículo no-motorizado se debe quitar en el plazo de 48 horas a partir recibir este aviso. Después que el tiempo, será juzgado abandonado y confiscado.
2. El término “propiedad abandonada” significa propiedad personal, con excepcion de un vehiculo de motor, eso se deja desatendido en un lugar público.
 - A. En la violación de la ley;
 - B. Por más de 48 horas; o
 - C. De una manera que interfiere con tráfico de vehículos o peatones.

La ciudad puede quitar propiedad abandonada a un lugar del impoundment señalado por el encargado de la ciudad, y puede disponer de la propiedad en la manera prevista en el capítulo 9-1 del código municipal de la ciudad de Austin.

Para más información 974-8119

Jefe del Policia

Employee/Empleado _____ Emp. # _____

Date affixed/Fecha puesta _____ Time/Hora _____

S 129001

NAME OF SELLER (LAST) (FIRST) (M)

DATE PURCHASED DATE

ADDRESS OF SELLER
DEALER MUST BE PHYSICALLY PRESENTED DRIVER'S LICENSE OR DPS IDENTIFICATION CARD

M
TIME PURCHASED TIME

IDENTIFICATION #	STATE	D.O.B.	WEIGHT	HEIGHT	SEX	RACE	TRANSACTION #
1							
2							

DEALER'S NAME ADDRESS TELEPHONE # DEALER'S REP. SIGNATURE

PURCHASER'S NAME ADDRESS DEALER'S NAME

COMPLETE DESCRIPTION OF PURCHASED GOODS INCLUDING SERIAL NUMBERS & IDENTIFYING MARKS & S

FOR THE PURCHASE PRICE SET ABOVE, THE UNDERSIGNED SELLER, WARRANTING GOOD TITLE, THAT TRANSFER THEREOF IS
AND THAT SUCH GOODS ARE FREE FROM ANY SECURITY INTEREST, OTHER LIEN, OR ENCUMBRANCE.
I CERTIFY THE ABOVE INFORMATION IS TRUE AND COMPLETE.

SIGNATURE OF SELLER _____

PD0109B

Vehicle and Equipment Repair Form

Date: _____ Time: _____ AM / PM Mileage _____

City # _____ Vehicle : _____
Vehicle Repair Shop

Shotgun / Stinger / RAT pulled by: _____

Reason for Repair: _____

Radio Shop

Mobile Vision	_____
Vehicle Radio	_____
Handi Talkie	_____
Light Bar	_____
Toughbook	_____
RAT	_____
Body Mic	_____
Hand Held Radar	_____
Lo-Jack	_____

Reason for Repair: _____

Print Name _____ Employee Number: _____

(Perforated Line)

Bottom portion to be filled out on collisions

APD Collision Report # _____ Damage to City Property Report # _____

Vehicle Issues that may have contributed to the accident/incident

_____ Mechanical problems	_____
_____ Tire problems	_____
_____ Brake failure	_____
_____ Other problems	_____

Print Name _____ Employee Number: _____

Shotgun / Stinger / RAT replaced by: _____

**AUSTIN POLICE DEPT.
715 E. 8th STREET
AUSTIN, TX 78701**

Date _____

Incident # _____

Date of incident _____

In order to further the investigation of the above incident
in which you were involved, please telephone for an
appointment with _____
of the Austin Police Department.

Call 974- _____

**AUSTIN POLICE DEPT.
715 E. 8th STREET
AUSTIN, TX 78701**

Fecha _____ **Numero de Incidente** _____
(Date) **(Incident Number)**

El _____ **usted reporto un incidente al Departamento de Policia**
(Fecha/Date)
de Austin. Hasta hoy no hay suficiente informacion para continuar investigando
este incidente. Para poder seguir investigando este incidente por favor llame al
(512) _____ **si tiene informacion adicional sobre este incidente**
o para hacer una cita con _____ **del**
(Investigador/Detective)
Departamento de Policia de Austin.

PD-0133S

AUSTIN POLICE DEPARTMENT

P.O. BOX 689001
AUSTIN, TX 78768-9001

DATE: _____

REPORT # _____
DATE OF INCIDENT: _____
INCIDENT REPORTED: _____

WE HAVE RECEIVED YOUR REPORT WITH THE AUSTIN POLICE DEPARTMENT. WE WILL NOTIFY YOU OF ANY UPDATES. IF YOU HAVE ANY NEW OR ADDITIONAL INFORMATION TO ADD TO THIS REPORT, PLEASE CALL DETECTIVE

_____ AT _____,

MONDAY THROUGH FRIDAY BETWEEN _____ A.M. AND _____ P.M.

PD-0134

Street Check (Circle one) CAD# _____

Airport FO Airport Warning Boat FO Boat Warning

GANG INTEL FO Warning

POINTED FIREARM AT PERSON Yes No

Date: _____ Time: _____ Name/EMP # _____

Location: _____

City: _____ State: _____ Zip: _____

Person Information

Last: _____ First: _____ MI: _____

R/S: _____ DOB: _____ Phone #: _____

Was race or ethnicity known before stop? Yes or No

Address: _____

City: _____ State: _____ Zip: _____

DL/ID# _____ St: _____

Hgt: _____ Wgt: _____ Hair _____ Eyes: _____

AKA: _____

Vehicle Information

LP# _____ LP State: _____ Exp Date: _____

Type: Auto Truck MC Veh Yr: _____ Make: _____

Color: _____

Violation: _____

Additional Information: _____

Circle the ones that applies to each:

Person Searched: Yes or No

Vehicle Searched: Yes or No

Search based on: (select up to 3)

Search based on: (select up to 3)

- 1 - Frisk for Safety
- 2 - Consent
- 3 - Probable Cause
- 4 - Incidental to arrest
- 5 - Contraband/evidence in plain view

- 1 - Frisk for safety
- 2 - Consent
- 3 - Probable Cause
- 4 - Incidental to arrest
- 5 - Contraband/evidence in plain view
- 6 - Inventory of towed vehicle

Search discovered: (select up to 3)

Search discovered: (select up to 3)

- 1- Weapons
- 2 - Cash
- 3 - Alcohol
- 4 - Other
- 5 - Nothing
- 6 - Drugs

- 1- Weapons
- 2 - Cash
- 3 - Alcohol
- 4 - Other
- 5 - Nothing
- 6 - Drugs

Reason for stop: (select up to 3)

- 1 Viol Transportation Vehicle Law
- 2 Viol Of Penal Code
- 3 Consensual Contact
- 4 Suspicious Person / Vehicle
- 5 Call for Service
- 6 Pre-existing Knowledge
- 7 Violation of City Ordinance
- 8 Other
- 9 Water Safety Act
- A Motor Vehicle Driver



ONLY FOR WARNINGS

This notice is given to you in an effort to obtain your full cooperation in preventing collisions. It is the belief of the Austin Police Department that when the public is well informed as to existing traffic regulations, they will comply willingly without penalty.

Will you help reduce collision in Austin?

This violation will not become a part of your permanent driving record.

Driver Signature: _____

APD CENTRAL RECORDS COPY

PD0138 Rev: 01/2010

Person Search - PS _____

Vehicle Search - VS _____

First space - Insert one of the following numbers

- 1 - Yes
- 2 - No

First space - Insert one of the following numbers

- 1 - Yes
- 2 - No

Second Space - Will indicate what the search was based on. Insert one of the following numbers.

- 1 - Frisk for Safety
- 2 - Consent
- 3 - Probable Cause

Second Space - Will indicate what the search was based on. Insert one of the following numbers.

- 1 - Frisk for Safety
- 2 - Consent
- 3 - Probable Cause

Third Space - Will indicate what was discovered or seized. Insert one of the following numbers.

- 1 - Weapons
- 2 - Cash
- 3 - Alcohol
- 4 - Other
- 5 - Nothing

Third Space - Will indicate what was discovered or seized. Insert one of the following numbers.

- 1 - Weapons
- 2 - Cash
- 3 - Alcohol
- 4 - Other
- 5 - Nothing

THIS IS A WARNING!

THERE IS NO PENALTY ASSESSED FOR THIS VIOLATION

COLOR _____ YR _____ MAKE _____ TYPE _____ CAD # _____

EXP. DATE _____ LIC STATE _____ VEH LIC. # _____

DRIVER ST. _____ LIC. # _____ CLASS: OPER COMM CHAUF

RACE _____ SEX _____ DOB _____

LAST NAME _____ FIRST NAME _____ Mi _____

ADDRESS _____ STATE _____ ZIP _____

DATE _____ TIME _____ LOCATION _____

VIOLATION _____



THIS NOTICE IS GIVEN TO YOU IN AN EFFORT TO OBTAIN YOUR FULL COOPERATION IN PREVENTING COLLISIONS. IT IS THE BELIEF OF THE AUSTIN POLICE DEPARTMENT THAT WHEN THE PUBLIC IS WELL INFORMED AS TO EXISTING TRAFFIC REGULATIONS, THEY WILL COMPLY WILLINGLY WITHOUT PENALTY.

WILL YOU HELP REDUCE COLLISIONS IN AUSTIN?

THIS VIOLATION WILL NOT BECOME A PART OF YOUR PERMANENT DRIVING RECORD

OFFICER _____ EMP.# _____

DRIVER _____

PD 0141

Rev. 9/2001

No C 5581

This coupon is valued at \$4.75 and may be exchanged for
Copiesof certain Police Record

AUSTIN
P.O. Box 689001
Austin, Texas 78768



POLICE
Data Resources
974-5212

City of Austin
DEPT.

PD0144(09-02)

No C10781

This coupon is valued at \$6.00 and may be exchanged for
Copiesof certain Police Records

AUSTIN
P.O. Box 689001
Austin, Texas 78768



POLICE
Data Resources
974-5212

City of Austin
DEPT.

PD0144A(09-02)

POLICE DEPARTMENT – CITY OF AUSTIN

POLICE NOTICE-JUNKED VEHICLE

This vehicle is in violation of Chapter 9-1 of the City Code of Austin as a junked vehicle.

1. This vehicle is a public nuisance – it must be removed within ten (10) days from the date of this notice.
2. Any request for a hearing to challenge whether or not this is a junked motor vehicle as defined by Section 683.071 of the Texas Transportation Code must be made to the Clerk of the Municipal Court, 700 East 7th, Austin, Texas 78701, either in person or in writing before the expiration of the ten (10) day period. This hearing is without the requirement of bond.
3. If no request for a hearing is received before the expiration of ten (10) days, it shall be conclusively presumed that said vehicle is a junked vehicle as defined by State Law and City Code.

For more information 974-8119

Chief of Police

DEPARTAMENTO DEL POLICÍA - CIUDAD DE AUSTIN

AVISO DEL POLICÍA - VEHÍCULO DE JUNKED

Este vehículo está en violación del capítulo 9-1 del código de la ciudad de Austin como a junked vehículo.

1. Este vehículo es un fastidio público - debe moverse dentro de diez (10) días la fecha de este aviso.
2. Cualquier pedido una audiencia al challenge si no esta es junked el vehiculo motorizado según lo definido por Section 683.071 Código Del Transporte De Tejas debe ser hecho al vendedor de la corte municipal, Calle 700 E. 7th, Austin, Texas 78701, en persona o en escribir antes de la expiración del período de diez (10) días. Esta audiencia no requiera fianza.
3. Si no se recibe ningún pedido una audiencia antes de la expiración de diez días, será presumido concluyente que el vehículo dicho junked según lo definido por State Law y código de la ciudad.

Para más información 974-8119

Jefe del Policia

Employee/Empleado _____ Emp. # _____

Date affixed/Fecha puesta _____ Time/Hora _____

**WARNING TO BE GIVEN BEFORE TAKING
ANY ORAL OR WRITTEN CONFESSION**

1. You have the right to remain silent and not make any statement at all and that any statement you make may be used against you and probably will be used against you at your trial;
2. Any statement you make may be used as evidence against you in court;
3. You have the right to have a lawyer present to advise you prior to and during any questioning;
4. If you are unable to employ a lawyer, you have the right to have a lawyer appointed to advise you prior to and during any questioning;
5. You have the right to terminate this interview at any time.

SPANISH VERSION

1. Tiene usted el derecho de mantener su silencio y decir absolutamente nada. Cualquier declaración que usted haga se podrá usar en su contra en la causa en que se le acusa;
2. Cualquier declaración que usted haga se podrá usar como evidencia en su contra en corte.
3. Tiene usted el derecho de tener un abogado presente porque él le aconseje antes de que se la hagan preguntas y durante el tiempo que se le esté haciendo preguntas.
4. Si no puede emplear un abogado, tiene usted el derecho a que se le asigne un abogado para que él le aconseje antes de o durante el tiempo que se le hagan preguntas.
5. Tiene usted el derecho de terminar esta entrevista en cualquier momento que usted desee.

I have received and understand the warning on the other side of this card. I agree to waive these Rights and to make a Statement.

Signature _____
(Person Warned)

Date _____

Time _____

Officer _____
(Witness)

Yo le recibí mis derechos que están escritos en el otro lado de esta tarjeta y los entiendo. Yo deseo abandonar esos derechos y voluntariamente hacer una declaración.

Firma _____
(Acusado)

Fecha _____

Hora _____

Oficial _____
(Testigo)

REGISTER FORM

A

B

CASH ON HAND

BEGINNING CHANGE COUNT

CURRENCY

1's
5's
10's
20's
50's
100's
Pennies
Nickels
Dimes
Quarters
Halves
Dollars
TOTAL CURRENCY
TOTAL CHECKS
TOTAL COUPONS
TOTAL SALES
LESS COUPONS

Beginning Receipt No.

Ending Receipt No.

(1) Report Sales
TOTAL

Voids (-)

Coupon (-)

(2) Coupon Books
TOTAL

Voids (-)

(3) Misc. Reports
TOTAL

Voids (-)

>> TOTAL

SALES PER REGISTER

Cash Sales

Check Sales

Coupon Sales

TOTAL SALES

LESS VOIDS (.....)

>> SALES PER REGISTER

>> SALES PER REGISTER

>> TOTAL SALES

OVER / UNDER

TOTAL SALES in Column A should match SALES PER REGISTER in Column B.

Date: Employee Name & Number:

Form: REGISTER.GW

Register Number:

**PAWNSHOP PROPERTY HOLD CARD
HOLD OR PICKED-UP ITEMS**

TICKET # _____ CASE # _____

DATE OF HOLD _____ CASE ASSIGNED TO _____

RECEIVED FROM _____

DESCRIPTION OF ITEM, SER. #, ETC. _____

_____ AMOUNT \$ _____

SOLD OR PAWNED BY _____

DATE & TIME PICKED UP _____ DEPT. _____

BY _____

DISPOSITION OF ITEMS _____

RELEASED TO: _____ ADD: _____

PD 0201 (8/78)

Routing: Green Copy—File with Off.

Yellow—Pawn Shop Detail

White—Pawn Shop Owner

AMERICAN MINORITY BUSINESS FORMS (812) 334-9348

56156

OUT-OF-SERVICE VEHICLE

DRIVER-VEHICLE EXAMINATION REPORT --- _____

TICKET NUMBER

This motor vehicle has been declared

OUT OF SERVICE

By the

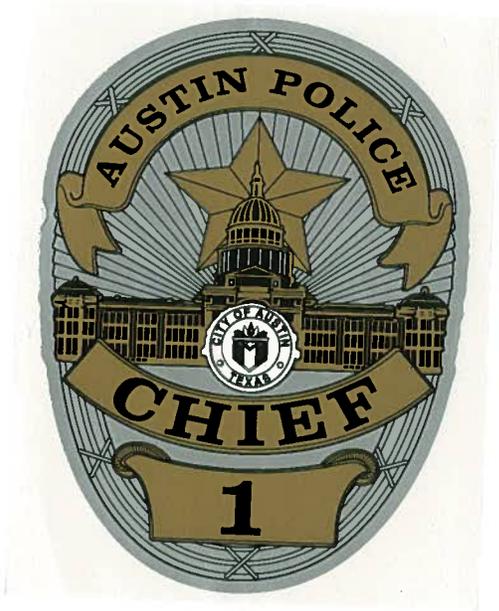
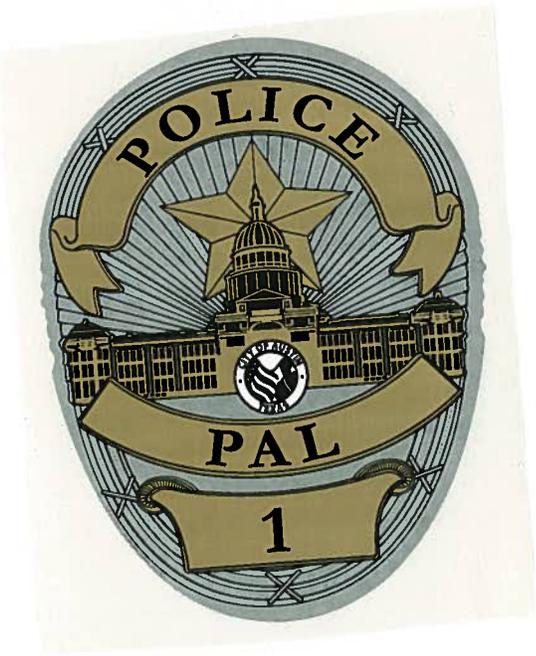
**AUSTIN POLICE DEPARTMENT
LICENSE AND WEIGHT SERVICE**

This vehicle is NOT to be operated until repaired

This sticker shall be removed only under the conditions stated on the "Out-of-Service Notice".

Officer _____ Emp. # _____ Date _____

PD-0211 (09/01)





False Alarm Notice

The Austin Police Department has answered a false alarm call at this location. Alarm calls are more than 97% false and Austin police officers respond to thousands of alarm calls each month. While responding to false alarms, officers are not available for emergency calls.

If you are operating an alarm system without a valid permit, you will be charged \$200 for each response to this location. Call the APD Alarm Administration Unit at (512) 974-5730 for a permit application, or go to: <https://apdalarm.austintexas.gov>

Help reduce false alarms. Call your alarm company for guidance in properly using your alarm system.

Date/Time: _____

Incident: _____

Officer: _____

Cite and Release
CAD #

CR 102161

(Circle one) Travis Co. Hays Co.

Date: Time: Name/Emp#

Location:

City: Zip:

Person Information

Last: First: MI:

R/S Ethnicity: Hisp NonHisp DOB

Was race or ethnicity known before stop? Yes or No

Address: Phone:

City: State: Zip:

DL/ID# ST:

Ht: Wt: Hair: Eyes: APD #

Vehicle Information

LP# LP State: Exp Date:

Type: Auto Truck MC Veh Yr: Make: Color:

Violation (Circle all that apply)

Poss. of Marijuana < 4 oz. Criminal Mischief - Class B
Graffiti - Class B Theft - Class B
Theft of Service - Class B Driving While License Invalid - Class B

Additional Information:

Circle those that apply to each category:

Person Searched: Yes or No Vehicle Searched: Yes or No

Search based on: (select up to 3) Search based on: (select up to 3)

1- Frisk/safety 3- Probable Cause 1 - Frisk/safety 3- Probable Cause
2 - Consent 4- Incidental to arrest 2 - Consent 4- Incidental to arrest
5 - Contraband / evidence in plain view 5 - Contraband / evidence in plain view
6 - Inventory of towed vehicle

Search discovered:(select up to 3) Search discovered:(select up to 3)

1- Weapons 4 - Other 1- Weapons 4 - Other
2 - Cash 5 - Nothing 2 - Cash 5 - Nothing
3 - Alcohol 6 - Drugs 3 - Alcohol 6 - Drugs

Reason for stop: (select up to 3)

1 - Viol Transportation Vehicle Law 6 - Pre-existing Knowledge
2 - Viol Of Penal Code 7 - Viol City Ordinance
3 -Consensual Contact 8 - Other
4 - Suspicious Person / Vehicle 9 - Water Safety Act
5 - Call For Service A - Motor Vehicle Driver

I promise to appear in court on .

I have received this written notice to appear and I will appear on the date and time designated on the back in order to enter a plea of guilty, not guilty or no contest to each violation listed on this summons.

This is not a plea of guilty, only a promise to appear.

Signature Date

PS _____ VS _____ RFS _____ CAD# _____

ARREST TKT CDL: HAZ MAT SPEC TANK DRIVER/VEHICLE INSPECTION
 COMM VEH 16 PASS BUS ACCIDENT 1. 2. 3. 4. 5.
 MED CARD EXP: M ___/Y ___ OVER 26,000 S.S.# _____ ROADSIDE FIXED

VIOL. DATE _____ VIOL. TIME: _____ AM _____ PM _____ COUNTY: _____ LOCATION: _____ BLOCK# _____ MM _____

OPERATOR NAME: (LAST) _____ (FIRST) _____ (MID. INIT) _____ D.O.B. _____ RACE/SEX: _____

OPERATOR Address: _____ CITY _____ STATE: _____ ZIP CODE _____

CDL A, B, C
 DL
 ID

DRIVER'S LICENSE #: _____ STATE: _____ HOME PHONE #: () _____ WORK PHONE#: () _____

MOTOR CARRIER: _____ US DOT #: _____

ADDRESS/CITY/STATE/ZIP CODE: _____ ICC/MC #: _____

OWNER: _____ ADDRESS: _____ TX DOT #: _____

#	TYPE	YEAR	REG. - MOYR	COLOR	MAKE	CO#	PLATE #	STATE
1								
2								
3								
4								

LOAD DISP: _____ PERMIT #: _____

RG WT #1 _____ RQ Wt #2: _____

GVWR # 1: _____ GVWR #2: _____

I HAVE RECEIVED THIS WRITTEN NOTICE TO APPEAR AT THE CITY OF AUSTIN MUNICIPAL COURT ON OR BEFORE THE APPEARANCE DATE AND ENTER A PLEA OF GUILTY, NOT GUILTY OR NO CONTEST TO EACH VIOLATION LISTED ON THIS TICKET.

COURT APPEARANCE DATE

DRIVER'S SIGNATURE

FAILURE TO APPEAR AND ENTER A PLEA WILL RESULT IN A WARRANT FOR YOUR ARREST (\$50.00 PER CHARGE), A HIGHER FINE PAYMENT, A REQUEST TO THE TEXAS DEPARTMENT OF PUBLIC SAFETY FOR DENIAL OF DRIVER LICENSE RENEWAL (A \$30.00 FEE MAY BE ADDED), AND A REFERRAL TO A COLLECTION AGENCY AFTER 60 DAYS WITH A POSSIBLE 30% FEE ADDED TO THE AMOUNT OWED.

COURT APPEARANCE TIME SEE REVERSE SIDE FOR COURT HOURS

(X)

THIS IS NOT A PLEA OF GUILTY, ONLY A PROMISE TO APPEAR.

COMMODITY: _____ ORIGIN: _____ DESTINATION: _____

- A - EXPLOSIVES A
- B - EXPLOSIVES B
- C - EXPLOSIVES C
- D - FLAMMABLE LIQUID
- E - FLAMMABLE SOLID
- F - FLAMMABLE GAS
- G - NONFLAMMABLE GAS
- H - CORROSIVES
- I - OXIDIZERS
- J - POISON A
- K - POISON B
- L - COMBUSTIBLE LIQUID
- M - RADIOACTIVE MATERIAL
- N - ORGANIC PEROXIDE
- O - IRRITATING MATERIAL
- P - ORM A B OR C
- R - ETIOLOGIC AGENT
- S - BLASTING AGENT
- T - CRYOGENICS
- Z - OTHER

CODE	RQ?	HW?

FOR HIRE? Y N INTERSTATE? Y N

ICC#

R.R.C.#

SHIPPING #

CONSIGNEE

SEAL #'S REMOVED

CVSA DECAL - TT

R	AXLE 1	AXLE 2	AXLE 3	AXLE 4	AXLE 5	AXLE 6	AXLE 7
L							

CONSIGNOR

DEPT SEAL #

INSTALLED

CVAS DECAL - TT

CVSA DECAL - ST

PLACARDS REQUIRED? Y N

REASON FOR STOP:

OFFICER:

EMP#

Violation	Ticket Issued	FED VIOLATION IDENTIFICATION CODE	UNIT NO.	OUT/SVS Y/N	OOS DISP	VIOLATION DISCOVERED	COURT VIOLATION CODE
A							
B							
C							
D							
E							

COMMENTS:

CONTINUATION SHEET? YES NO OFFICER EMP # VISUAL PACED RADAR LASER AIRCRAFT

ALLEGED SPEED SPEED LIMIT: RADAR CAL Y/N

Vehicle Pursuant to authority contained in TRC Chapter 644, I hereby declare "Out of Service" the vehicle (s) with defects followed by "Yes" in the Out of Service column of this report. No person shall remove the Out of Service stickers applied to these vehicles or operate such vehicles until the out of service defects have been repaired and the vehicles have been restored to safe operating condition, or proper operating authority has been obtained.

Driver Pursuant to authority contained in TRC Chapter 644, I hereby notify and declare the driver named in this report "Out of Service. No motor carrier shall permit or require driver to drive or Operate any motor vehicle unit.

OUT OF SERVICE (OOS) DISPOSITIONS:
A - Repaired at Scene/Obtained Oper. Authority
B - Towed/Escorted to Repair Service
D - Other
U - Unknown N - Driver OOS

DRIVER, IF THERE ARE VIOLATIONS SHOWN ABOVE, PLEASE COMPLY WITH DIRECTIONS ON THE BACK SIDE OF THIS CITATION

REPORT PREPARED BY _____ A SERVICE/ID/REGION/AREA _____ B TIME COMPLETED _____ AM _____ PM _____ COPY RECEIVED BY: _____

COURT COPY

CITY OF AUSTIN LICENSE AND WEIGHTS CITATION - OFFENSE CONTINUATION SHEET

REV. 4/04

PS _____	VS _____	RFS _____	CAD #:
CITATION NUMBER	OPERATOR LAST NAME	FIRST NAME	MIDDLE INIT
NAME OF BUSINESS CARRIER OR LESSEE		OFFICER	EMPLOYEE #
			AGENCY

VIOLATIONS

Violation	Ticket Issued	FED VIOLATION IDENTIFICATION CODE	UNIT NO.	OUT/ SVS Y/N	OOS DISP	VIOLATION DISCOVERED	COURT VIOLATION CODE
F							
G							
H							
I							
J							
K							
L							
M							
N							
O							
P							
Q							
R							
S							
T							
U							
V							
W							
X							
Y							
Z							

<p>I HAVE RECEIVED THIS WRITTEN NOTICE TO APPEAR AT THE CITY OF AUSTIN MUNICIPAL COURT ON OR BEFORE THE APPEARANCE DATE AND ENTER A PLEA OF GUILTY, NOT GUILTY OR NO CONTEST TO EACH VIOLATION LISTED ON THIS TICKET.</p> <p>FAILURE TO APPEAR AND ENTER A PLEA WILL RESULT IN A WARRANT FOR YOUR ARREST (\$50.00 PER CHARGE), A HIGHER FINE PAYMENT, A REQUEST TO THE TEXAS DEPARTMENT OF PUBLIC SAFETY FOR DENIAL OF DRIVER LICENSE RENEWAL (A \$30.00 FEE MAY BE ADDED), AND A REFERRAL TO A COLLECTION AGENCY AFTER 60 DAYS WITH A POSSIBLE 30% FEE ADDED TO THE AMOUNT OWED.</p>	<p>COURT APPEARANCE DATE</p> <p style="text-align: center;">____/____/____</p> <p style="text-align: center;">COURT APPEARANCE TIME SEE REVERSE SIDE FOR COURT HOURS</p>	<p>DRIVER'S SIGNATURE</p> <p style="text-align: center;">(X)</p> <p style="text-align: center;">THIS IS NOT A PLEA OF GUILTY, ONLY A PROMISE TO APPEAR.</p>
---	--	---

<input type="checkbox"/> Vehicle: Pursuant to authority contained in TRC Chapter 644, I hereby declare "Out of Service" the vehicle (s) with defects followed by "Yes" in the Out of Service column of this report. No person shall remove the Out of Service stickers applied to these vehicles or operate such vehicles until the out of service defects have been repaired and the vehicles have been restored to safe operating condition, or proper operating authority has been obtained.	<input type="checkbox"/> Driver: Pursuant to authority contained in TRC Chapter 644, I hereby notify and declare the driver named in this report Out of Service. No motor carrier shall permit or require driver to drive or Operate any motor vehicle unit.
---	--

OUT OF SERVICE (OSS) DISPOSITIONS:

A - Repaired at Scene/Obtained Oper. Authority
 B - Towed/Escorted to Repair Service
 D - Other
 U - Unknown N - Driver OOS

NOTE TO DRIVER: THIS REPORT MUST BE FURNISHED TO THE MOTOR CARRIER WHOSE NAME APPEARS ON THIS REPORT. **NOTE TO MOTOR CARRIER:** THE TEXAS TRANSPORTATION CODE REQUIRES THE MOTOR CARRIER TO CERTIFY THAT ALL VIOLATIONS NOTED ON THIS REPORT HAVE BEEN CORRECTED AND ACTION HAS BEEN TAKEN TO ASSURE COMPLIANCE WITH THE TEXAS TRANSPORTATION CODE. FILL OUT THE REQUIRED CERTIFICATION ON THE BACK OF THIS CITATION AND RETURN TO THE CITY OF AUSTIN MUNICIPAL COURT WITHIN 15 DAYS.

STATUTORY WARNING

DIC-24 (Rev. 9/05)

SUBJECT'S NAME DL NO./STATE DOB

PHYSICAL DESCRIPTION (if unlicensed) Race: _____ Sex: _____ Height: _____ Weight: _____ Eyes: _____ Hair: _____

DATE OF ARREST: _____ TIME OF ARREST: _____ COUNTY OF ARREST: _____

You are under arrest for an offense arising out of acts alleged to have been committed while you were operating a motor vehicle or watercraft in a public place while intoxicated or an offense under Section 106.041, Alcoholic Beverage Code. You will be asked to give a specimen of your breath and/or blood. The specimen will be analyzed to determine the alcohol concentration or the presence of a controlled substance, drug, dangerous drug or other substance in your body.

If you refuse to give the specimen, that refusal may be admissible in a subsequent prosecution. Your license, permit or privilege to operate a motor vehicle will be suspended or denied for not less than 180 days, whether or not you are subsequently prosecuted for this offense.

If you are 21 years of age or older and submit to the taking of a specimen and an analysis of the specimen shows that you have an alcohol concentration of 0.08 or more, your license, permit or privilege to operate a motor vehicle will be suspended or denied for not less than 90 days, whether or not you are subsequently prosecuted for this offense.

If you are younger than 21 years of age and have any detectable amount of alcohol in your system, your license, permit or privilege to operate a motor vehicle will be suspended or denied for not less than 60 days. However, if you submit to the taking of a specimen and an analysis of the specimen shows that you have an alcohol concentration of less than 0.08, you may be subject to criminal penalties less severe than those provided for under Chapter 49, Penal Code.

If you refuse to give the specimen, or if the specimen shows that you have an alcohol concentration of 0.08 or more, you may be disqualified from driving a commercial motor vehicle for a period of not less than one year.

You may request a hearing on the suspension or denial. This request must be received by the Texas Department of Public Safety at its headquarters in Austin, Texas, no later than 15 days after you receive or are presumed to have received notice of suspension or denial. The request can be made by written demand, fax, or other form prescribed by the Department.

I certify that I have informed you both orally and in writing of the consequences of refusing to submit to the taking of a specimen or providing a specimen. I have provided you with a complete and true copy of this statutory warning.

I am now requesting a specimen of your **Breath** **Blood**

Subject refused to allow the taking of a specimen and further refused to sign below as requested by this officer.

OR

Subject refused to allow the taking of a specimen as evidenced by his/her signature below.

Subject's Signature

I further certify that because you are a child as defined in Section 51.02, Family Code, the above request for a specimen and your response have been videotaped.

FOR DEPARTMENT USE ONLY

Officer's Signature

Officer's Printed Name

Agency

Telephone No.

ADVERTENCIA ESTATUTARIA

DIC-24S (Rev. 9/05)

SUBJECT'S NAME _____ DL NO./STATE _____ DOB _____

PHYSICAL DESCRIPTION (if unlicensed) Race: _____ Sex: _____ Height: _____ Weight: _____ Eyes: _____ Hair: _____

DATE OF ARREST: _____ TIME OF ARREST: _____ COUNTY OF ARREST: _____

Queda usted detenido por motivo de un delito surgiendo de determinadas acciones que se alega fueron cometidas mientras manejaba un vehículo motorizado o una embarcación en un lugar público estando intoxicado, o un delito según la Sección 106.041 del Código de Bebidas Alcohólicas. Se le solicitará una muestra de su aliento y/o sangre. La muestra será analizada para determinar la concentración de alcohol o la existencia de alguna sustancia controlada, fármaco, droga peligroso u otra sustancia en su cuerpo.

Si usted se niega a proporcionar una muestra, esa denegación podría ser admisible en un enjuiciamiento posterior. Su licencia, permiso o privilegio para manejar un vehículo motorizado será suspendido o negado por un período no inferior a ciento ochenta (180) días, independientemente de si llegara a ser enjuiciado posteriormente por este delito.

Se es mayor de veintiún (21) años de edad y acuerda proporcionar una muestra y el análisis de la muestra indica una concentración de alcohol de 0,08 o mayor, su licencia, permiso o privilegio para manejar un vehículo motorizado será suspendido o negado por un período no inferior a noventa (90) días, independientemente de si llegara a ser enjuiciado posteriormente por este delito.

Si es menor de veintiún (21) años de edad y tiene cualquier cantidad perceptible de alcohol en su cuerpo, su licencia, permiso o privilegio para manejar un vehículo motorizado será suspendido o negado por un período no inferior a sesenta (60) días. Sin embargo, si acuerda proporcionar una muestra y el análisis de la muestra indica que tiene una concentración de alcohol de menos de 0,08, es posible que su castigo penal sea menor que los castigos que se han establecido conforme al Capítulo 49 del Código Penal.

Si usted se niega a proporcionar una muestra, o si la muestra indica que usted tiene una concentración de alcohol de 0,08 ó mayor, usted podría quedar inhabilitado para manejar vehículos motorizados comerciales por un período mínimo de un año.

Usted puede solicitar una audiencia para disputar la suspensión o la negación. El Departamento de Seguridad Pública de Tejas debe recibir la solicitud correspondiente en su sede central en Austin, Texas dentro de un plazo máximo de quince (15) días a partir de la fecha en que usted recibe, o se supone que haya recibido, el aviso de suspensión o negación. Puede hacer la solicitud por correo, por fax o por medio de algún otro procedimiento que haya establecido el Departamento.

Por la presente certifico que le he informado, por vía oral y escrita, de las consecuencias de negarse a que le tomen una muestra o a proporcionar una muestra. Le he facilitado una copia fiel y completa de esta advertencia estatutaria.

Ahora le solicito una muestra de su Aliento Sangre

El/la sujeto/a se negó a permitir que le tomaran una muestra y además se negó a firmar donde se indica más adelante según la solicitud de este oficial.

O

El/la sujeto/a se negó a permitir que le tomaran una muestra según lo indica su firma a continuación:

(Firma del/de la sujeto/a)

Certifico además que, siendo usted menor de edad según se especifica en la Sección 51.02 del Código Familiar, esta solicitud de una muestra y la respuesta que me ha dado al respecto se han documentado en cinta de vídeo.

FOR DEPARTMENT USE ONLY

Officer's Signature

Officer's Printed Name

Agency

Telephone No.

**NOTICE OF SUSPENSION
TEMPORARY DRIVING PERMIT**

DIC-25 (Rev. 9/05)

SUBJECT'S NAME _____ DL NO./STATE _____ DOB _____

ADDRESS _____

PHYSICAL DESCRIPTION (if unlicensed) Race: _____ Sex: _____ Height: _____ Weight: _____ Eyes: _____ Hair: _____

DATE OF ARREST: _____ TIME OF ARREST: _____ COUNTY OF ARREST: _____

YOUR LICENSE, PERMIT OR PRIVILEGE TO OPERATE A MOTOR VEHICLE WILL BE SUSPENDED OR DENIED EFFECTIVE 40 DAYS AFTER THE DATE YOU RECEIVE THIS NOTICE BECAUSE YOU:

ADULT:

- REFUSED** to provide a specimen or specimens of breath or blood following an arrest for an offense prohibiting the operation of a motor vehicle or watercraft while intoxicated, while under the influence of alcohol, or while under the influence of a controlled substance.
- PROVIDED** a specimen of breath or blood, and an analysis of the specimen showed an alcohol concentration of .08 or greater following an arrest for an offense involving the operation of a motor vehicle.

MINOR (Under 21):

- REFUSED** to provide a specimen or specimens of breath or blood following an arrest for an offense prohibiting the operation of a motor vehicle or watercraft while intoxicated, while under the influence of alcohol, or while under the influence of a controlled substance.
- PROVIDED** a specimen of breath or blood, and an analysis of the specimen showed either an alcohol concentration of .08 or greater or a detectable amount of alcohol following an arrest for an offense involving the operation of a motor vehicle.
- WERE NOT REQUESTED TO SUBMIT** to the taking of a specimen following an arrest involving the operation of a motor vehicle, as the presence of alcohol was detected or measured by other means.

If your Texas driver license was confiscated, this document will serve as your temporary driving permit. It is subject to the same restrictions and endorsements as your Texas driver license. If you hold a commercial driver license, this permit authorizes the operation of commercial motor vehicles. This permit does not provide you with any driving privileges if you do not have a Texas driver license or if your Texas driver license is expired, suspended, revoked, cancelled, or disqualified. This permit is valid for 40 days from the date of service shown below. If you request a hearing, this permit will remain in effect until the administrative law judge makes a final decision in your case.

Driver License Confiscated: Yes No If no, explain _____

Date Notice Served: _____

Officer's Signature _____

Officer's Printed Name _____

Agency _____

Telephone No. _____

FOR DEPARTMENT USE ONLY

DRIVER INFORMATION

You may request a hearing to contest the suspension by calling (800) 394-9913, faxing (512) 424-2650 or writing the Texas Department of Public Safety, Driver Improvement Bureau, at PO Box 4040, Austin, Texas 78765-4040. All correspondence must include the following information: Full name, date of birth, driver license number and state, current mailing address, home and daytime telephone numbers, date and county of arrest, arresting agency, arresting officer, whether the test was failed, refused or not requested, and such other information as requested by the Department. Please specify if you wish to have your hearing by telephone or in person. **The request for hearing must be received by the Texas Department of Public Safety no later than 15 days after you receive or are presumed to have received notice of suspension. Failure to request a hearing within this time is a waiver of your right to a hearing.** You will be notified of the date, time, and location of your hearing. You will be required to pay a \$125 reinstatement fee to the Texas Department of Public Safety, Driver Improvement Bureau, PO Box 15999, Austin, Texas 78761-5999, in addition to any other fees required by law. See reverse side for periods of suspension and statutory references.

ADULTS:

Refused to provide a specimen or specimens of breath or blood following an arrest for an offense prohibiting the operation of a motor vehicle or watercraft while intoxicated, while under the influence of alcohol, or while under the influence of a controlled substance (Tex. Transp. Code Ann. Ch. 724):

- 180 DAYS First Offense
- 2 YEARS If previously suspended for failing or refusing a breath or blood test or previously suspended for a DWI, Intoxication Assault or Intoxication Manslaughter conviction during the 10 years preceding the date of arrest.

Provided a specimen of breath or blood with an alcohol concentration of 0.08 or greater following an arrest for an offense under Section 49.04, 49.07 or 49.08, Penal Code, involving the operation of a motor vehicle (Tex. Transp. Code Ann. Ch. 524):

- 90 DAYS First Offense
- 1 YEAR If previously suspended for failing or refusing a breath or blood test or previously suspended for a DWI, Intoxication Assault or Intoxication Manslaughter conviction during the 10 years preceding the date of arrest.

MINORS (UNDER 21 YEARS OF AGE):

Refused to provide a specimen or specimens of breath or blood following an arrest for an offense prohibiting the operation of a motor vehicle or watercraft while intoxicated, while under the influence of alcohol or while under the influence of a controlled substance (Tex. Transp. Code Ann. Ch. 724):

- 180 DAYS First Offense
- 2 YEARS If previously suspended for failing or refusing a breath or blood test or previously suspended for a DWI, Intoxication Assault or Intoxication Manslaughter conviction during the 10 years preceding the date of arrest.

Provided a specimen of breath or blood with an alcohol concentration of 0.08 or greater or a detectable amount of alcohol following an arrest for an offense under Section 49.04, 49.07 or 49.08, Penal Code, or Section 106.041, Alcoholic Beverage Code, involving the operation of a motor vehicle (Tex. Transp. Code Ann. Ch. 524):

- 60 DAYS First Offense
- 120 DAYS If previously convicted of an offense under Sections 49.04, 49.07 or 49.08, Penal Code, or Section 106.041, Alcoholic Beverage Code, involving the operation of a motor vehicle.
- 180 DAYS If previously convicted twice or more of an offense under Sections 49.04, 49.07 or 49.08, Penal Code, or Section 106.041, Alcoholic Beverage Code, involving the operation of a motor vehicle.

Were not requested to provide a specimen of breath or blood following an arrest for an offense under Section 49.04, 49.07 or 49.08, Penal Code, or Section 106.041, Alcoholic Beverage Code, involving the operation of a motor vehicle, as the presence of alcohol was detected or measured by other means (Tex. Transp. Code Ann. Ch. 524):

- 60 DAYS First Offense
- 120 DAYS If previously convicted of an offense under Sections 49.04, 49.07 or 49.08, Penal Code, or Section 106.041, Alcoholic Beverage Code, involving the operation of a motor vehicle.
- 180 DAYS If previously convicted twice or more of an offense under Sections 49.04, 49.07 or 49.08, Penal Code, or Section 106.041, Alcoholic Beverage Code, involving the operation of a motor vehicle.

COMMERCIAL DRIVER LICENSE (CDL) HOLDERS: Pursuant to Tex. Transp. Code Ann. Chapter 522, your commercial driving privilege will be disqualified for one year (three years if transporting hazardous material required to be placarded) if you refused to submit to a test under Chapter 724 to determine your alcohol concentration or the presence in your body of a controlled substance or drug while operating a motor vehicle in a public place; or if an analysis of your breath or blood under Chapter 524 determines that you had an alcohol concentration of 0.08 or more while operating a motor vehicle, other than a commercial motor vehicle, in a public place.

DRIVER LICENSE REINSTATEMENT FORM

Name _____ DL No. _____ DOB _____

Address _____

You are required to pay a \$125 fee to reinstate your driver license. Payment must be made in the form of a personal check, cashier's check or money order made payable to the Texas Department of Public Safety. Please complete this form and return it, along with your reinstatement fee, to the Texas Department of Public Safety at the following address:

DRIVER IMPROVEMENT BUREAU
PO BOX 15999
AUSTIN TX 78761 5000

**AVISO DE SUSPENSIÓN
PERMISO DE CONDUCIR PROVISIONAL**

DIC-25S (Rev. 9/05)

SUBJECT'S NAME _____

DL NO./STATE _____

DOB _____

ADDRESS _____

PHYSICAL DESCRIPTION (if unlicensed) Race: _____ Sex: _____ Height: _____ Weight: _____ Eyes: _____ Hair: _____

DATE OF ARREST: _____ TIME OF ARREST: _____ COUNTY OF ARREST: _____

SU LICENCIA, PERMISO O PRIVILEGIO PARA MANEJAR UN VEHÍCULO MOTORIZADO SERÁ SUSPENDIDO O NEGADO, CON VIGENCIA A CUARENTA (40) DÍAS A PARTIR DE LA FECHA EN QUE RECIBE ESTE AVISO POR CUALQUIERA DE LAS SIGUIENTES RAZONES:

ADULTO:

- USTED SE NEGÓ** a proporcionar una(s) muestra(s) de aliento o sangre después de haber sido detenido por motivo de un delito que prohíbe el manejo de un vehículo motorizado o una embarcación estando intoxicado, bajo la influencia del alcohol o bajo la influencia de una sustancia controlada.
- USTED PROPORCIONÓ** una muestra de aliento o sangre después de haber sido detenido por motivo de un delito relacionado con el manejo de un vehículo motorizado, y un análisis de la muestra indicó una concentración de alcohol de, 0,08 ó mayor

MENOR (Menor de 21 años):

- USTED SE NEGÓ** a proporcionar una(s) muestra(s) de aliento o sangre después de haber sido detenido por motivo de un delito que prohíbe el manejo de un vehículo motorizado o una embarcación estando intoxicado, bajo la influencia del alcohol o bajo la influencia de una sustancia controlada
- USTED PROPORCIONÓ** una muestra de aliento o sangre después de haber sido detenido por motivo de un delito relacionado con el manejo de un vehículo motorizado, y un análisis de la muestra indicó uno de los siguientes resultados: una concentración de alcohol de, 0,08 ó mayor, o una cantidad perceptible de alcohol.
- A USTED NO SE LE SOLICITÓ** una muestra después de haber sido detenido por motivo de un delito relacionado con el manejo de un vehículo motorizado debido a que se pudo detectar o medir la presencia de alcohol por otros medios.

En caso de que su licencia de conducir haya sido confiscada, este documento le servirá de permiso de conducir provisional, estando sujeto a las mismas restricciones y anotaciones que su licencia de conducir de Tejas. En caso de tener una licencia comercial este permiso le autoriza a manejar vehículos motorizados comerciales. Este permiso no le concede ninguna autoridad para conducir si no tiene una licencia de conducir de Tejas, o si su licencia de conducir de Tejas está vencida, suspendida, revocada, cancelada o descalificada. Este permiso tiene una vigencia de 40 días a partir de la fecha en que le fue entregado, fecha que consta más adelante en este documento. En caso de solicitar una audiencia referente a este caso, este permiso tendrá vigencia hasta que el juez de derecho administrativo correspondiente haya pronunciado su decisión final al respecto.

Licencia de conducir confiscada: **SI** **No** En caso negativo, explicar porqué _____

Fecha de entrega del aviso: _____

Officer's Signature _____

Officer's Printed Name _____

Agency _____

Telephone No. _____

FOR DEPARTMENT USE ONLY

DATOS PARA EL CONDUCTOR

Usted puede solicitar una audiencia para disputar la suspensión: por teléfono, llamando al (800) 394-9913, por fax al (512) 424-2650, o por escrito al Departamento de Seguridad Público de Tejas, enviando su carta a la siguiente dirección: Texas Department of Public Safety, Driver Improvement Bureau, PO Box 4040, Austin, Texas 78765-4040. Deben constar en toda la correspondencia los siguientes datos: su nombre completo; su fecha de nacimiento; el número de su licencia de conducir y el estado en el que fue expedida; la dirección donde actualmente recibe su correo; los números de teléfono de su casa y donde se le puede localizar durante el día; la fecha de su arresto y el condado donde fue detenido; la agencia que le arrestó y el oficial responsable; si el examen no fue aprobado, fue rehusado o no fue solicitado, y cualquier otra información solicitada por el Departamento. Sirvase indicar si prefiere que su audiencia se celebre en persona o por teléfono. El Departamento de Seguridad Pública de Tejas debe recibir su solicitud para una audiencia dentro de un plazo máximo de quince (15) días a partir de la fecha en que usted recibe, o se supone que haya recibido, el aviso de suspensión. Los que no solicitan la audiencia dentro de este plazo renuncian automáticamente su derecho a tener una audiencia. Se le comunicará la fecha, la hora y el lugar de su audiencia. Además de los pagos que pudieran corresponder por ley, deberá pagar \$125 en concepto de la reactivación de su licencia al: Texas Department of Public Safety, Driver Improvement Bureau, PO Box 15999, Austin, Texas 78761-5999. Al dorso encontrará una explicación de los períodos de suspensión y las referencias estatutarias.

DPS Copy—White

Driver's Copy—Yellow

DURACIÓN DE LOS PERÍODOS DE SUSPENSIÓN

ADULTOS:

Se negó a proporcionar una(s) muestra(s) de aliento o sangre después de haber sido detenido por motivo de un delito que prohíbe el manejo de un vehículo motorizado o una embarcación estando intoxicado, bajo la influencia del alcohol o bajo la influencia de una sustancia controlada según lo dispuesto por el capítulo 724 del Apéndice del Código de Transporte de Tejas:

180 DÍAS 2 AÑOS	Primer delito Si ha sido suspendido anteriormente por haber rehusado tomar o no haber aprobado el examen del aliento o la sangre, o si ha sido suspendido anteriormente por una condena de DWI (manejar en estado de embriaguez), asalto en estado de embriaguez u homicidio impremeditado en estado de embriaguez durante los 10 años anteriores a la fecha del arresto.
--------------------	--

Proporcionó una muestra de aliento o sangre con una concentración de alcohol de 0,08 ó mayor después de haber sido detenido por cometer un delito según las Secciones 49.04, 49.07 ó 49.08 del Código Penal, relacionado con el manejo de un vehículo motorizado según lo dispuesto por el capítulo 524 del Apéndice del Código de Transporte de Tejas:

90 DÍAS 1 AÑO	Primer delito Si ha sido suspendido anteriormente por haber rehusado tomar o no haber aprobado el examen del aliento o la sangre, o si ha sido suspendido anteriormente por una condena de DWI (manejar en estado de embriaguez), asalto en estado de embriaguez u homicidio impremeditado en estado de embriaguez durante los 10 años anteriores a la fecha del arresto.
------------------	--

MENORES (MENORES DE 21 AÑOS DE EDAD):

Se negó a proporcionar una(s) muestra(s) de aliento o sangre después de haber sido detenido por motivo de un delito que prohíbe el manejo de un vehículo motorizado o una embarcación estando intoxicado, bajo la influencia del alcohol o bajo la influencia de una sustancia controlada según lo dispuesto por el capítulo 724 del Apéndice del Código de Transporte de Tejas:

180 DÍAS 2 AÑOS	Primer delito Si ha sido suspendido anteriormente por haber rehusado tomar o no haber aprobado el examen del aliento o la sangre, o si ha sido suspendido anteriormente por una condena de DWI (manejar en estado de embriaguez), asalto en estado de embriaguez u homicidio impremeditado en estado de embriaguez durante los 10 años anteriores a la fecha del arresto.
--------------------	--

Proporcionó una muestra de aliento o sangre con una concentración de alcohol de 0,08 o mayor o con una cantidad perceptible de alcohol, después de haber sido detenido por cometer un delito relacionado con el manejo de un vehículo motorizado según las Secciones 49.04, 49.07 ó 49.08 del Código Penal, o la Sección 106.041 del Código de Bebidas Alcohólicas, según lo dispuesto por el capítulo 524 del Apéndice del Código de Transporte de Tejas:

60 DÍAS	Primer delito
120 DÍAS	Si ha sido condenado anteriormente por haber cometido un delito relacionado con el manejo de un vehículo motorizado según las Secciones 49.04, 49.07 ó 49.08 del Código Penal, o la Sección 106.041 del Código de Bebidas Alcohólicas.
180 DÍAS	Si ha sido condenado dos veces o más anteriormente por haber cometido un delito relacionado con el manejo de un vehículo motorizado según las Secciones 49.04, 49.07 ó 49.08 del Código Penal, o la Sección 106.041 del Código de Bebidas Alcohólicas.

No se le solicitó una muestra de aliento o sangre después de haber sido detenido por motivo de un delito relacionado con el manejo de un vehículo motorizado según las Secciones 49.04, 49.07 ó 49.08 del Código Penal, o la Sección 106.041 del Código de Bebidas Alcohólicas, debido a que se pudo detectar o medir la presencia de alcohol por otros medios, según lo dispuesto por el capítulo 524 del Apéndice del Código de Transporte de Tejas:

60 DÍAS	Primer delito
120 DÍAS	Si ha sido condenado anteriormente por haber cometido un delito relacionado con el manejo de un vehículo motorizado según las Secciones 49.04, 49.07 ó 49.08 del Código Penal, o la Sección 106.041 del Código de Bebidas Alcohólicas.
180 DÍAS	Si ha sido condenado dos veces o más anteriormente por haber cometido un delito relacionado con el manejo de un vehículo motorizado según las Secciones 49.04, 49.07 ó 49.08 del Código Penal, o la Sección 106.041 del Código de Bebidas Alcohólicas.

PORTADORES DE LA LICENCIA DE CONDUCIR COMERCIAL (CDL): Conforme al Cap. 522 del An. del Código de Transp. de Tejas, su privilegio para manejar vehículos comerciales quedará descalificado por un año (tres años en caso de transportar material peligroso que requiere letrado) si se niega a tomar la prueba según Cap. 724 para determinar la concentración de alcohol que tiene en la sangre o la presencia en su cuerpo de alguna sustancia controlada o droga mientras operaba un vehículo motorizado en un lugar público; o si un análisis de su aliento o sangre según Cap. 524 determina que tenía una concentración de alcohol de 0,08 ó mayor mientras operaba un vehículo motorizado, que no fuera vehículo motorizado comercial, en un lugar público.

FORMULARIO PARA LA REACTIVACIÓN DE LA LICENCIA DE CONDUCIR

Nombre: _____

Nº de la licencia de conducir: _____ Fecha de nacimiento: _____

Dirección: _____

La reactivación de la licencia de conducir se logra mediante el pago de \$125. El pago debe efectuarse por medio de cheque personal, cheque bancario o giro postal a nombre de: Texas Department of Public Safety. Sírvase completar este formulario y enviarlo, junto con el pago correspondiente a la reactivación de su licencia, a la siguiente dirección:

DRIVER IMPROVEMENT BUREAU
TEXAS DEPARTMENT OF PUBLIC SAFETY
PO BOX 15999
AUSTIN TX 78761-5999

Law Enforcement and TxDOT Use ONLY

FATAL CMV SCHOOL BUS RAILROAD MAB SUPPLEMENT ACTIVE SCHOOL ZONE

Total Num. Units: _____ Total Num. Prns.: _____ TxDOT Crash ID: _____



Texas Peace Officer's Crash Report (Form CR-3 1/1/2015)
Mail to: Texas Department of Transportation, Crash Data and Analysis, P.O. Box 149349, Austin, TX 78714. Questions? Call 844/274-7457
Refer to Attached Code Sheet for Numbered Fields

*=These fields are required on all additional sheets submitted for this crash (ex.: additional vehicles, occupants, injured, etc.).

Page ___ of ___

*Crash Date (MM/DD/YYYY)		*Crash Time (24HRMM)		Case ID		Local Use		
*County Name				*City Name				<input type="checkbox"/> Outside City Limit
In your opinion, did this crash result in at least \$1,000 damage to any one person's property?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Latitude (decimal degrees)		Longitude (decimal degrees)		
ROAD ON WHICH CRASH OCCURRED								
*1 Rdwy. Sys.		*Hwy. Num.		2 Rdwy. Part		Block Num.		
3 Street Prefix		* Street Name		4 Street Suffix				
<input type="checkbox"/> Crash Occurred on a Private Drive or Road/Private Property/Parking Lot		<input type="checkbox"/> Toll Road/Toll Lane		Speed Limit		Const. Zone <input type="checkbox"/> Yes <input type="checkbox"/> No		
Workers Present <input type="checkbox"/> Yes <input type="checkbox"/> No		Street Desc.						
INTERSECTING ROAD, OR IF CRASH NOT AT INTERSECTION, NEAREST INTERSECTING ROAD OR REFERENCE MARKER								
At Int. <input type="checkbox"/> Yes <input type="checkbox"/> No		1 Rdwy. Sys.		Hwy. Num.		2 Rdwy. Part		
Block Num.		3 Street Prefix		Street Name		4 Street Suffix		
Distance from Int. or Ref. Marker		<input type="checkbox"/> FT <input type="checkbox"/> MI		3 Dir. from Int. or Ref. Marker		Reference Marker		
Street Desc.		RRX Num.						
Unit Num.		5 Unit Desc.		<input type="checkbox"/> Parked Vehicle <input type="checkbox"/> Hit and Run		LP State		
LP Num.		VIN						
Veh. Year		6. Veh. Color		Veh. Make		Veh. Model		
7 Body Style		<input type="checkbox"/> Pol., Fire, EMS on Emergency (Explain in Narrative if checked)						
8 DL/ID Type		DL/ID State		DL/ID Num.		9 DL Class		
10 CDL End.		11 DL Rest.		DOB (MM/DD/YYYY)				
Address (Street, City, State, ZIP)								
Person Num.		12 Prsn. Type		13 Seat Position		Name: Last, First, Middle		
Enter Driver or Primary Person for this Unit on first line		14 Injury Severity		Age		15 Ethnicity		
16 Sex		17 Eject.		18 Restr.		19 Airbag		
20 Helmet		21 Sol.		22 Alc. Spec.		Alc. Result		
23 Drug Spec.		24 Drug Result		25 Drug Category				
Not Applicable - Alcohol and Drug Results are only reported for Driver/Primary Person for each Unit.								
<input type="checkbox"/> Owner <input type="checkbox"/> Lessee		Owner/Lessee Name & Address						
Proof of Fin. Resp. <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Expired <input type="checkbox"/> Exempt		26 Fin. Resp. Type		Fin. Resp. Name		
Fin. Resp. Phone Num.		27 Vehicle Damage Rating 1		27 Vehicle Damage Rating 2		Vehicle Inventoried <input type="checkbox"/> Yes <input type="checkbox"/> No		
Towed By		Towed To						
Unit Num.		5 Unit Desc.		<input type="checkbox"/> Parked Vehicle <input type="checkbox"/> Hit and Run		LP State		
LP Num.		VIN						
Veh. Year		6. Veh. Color		Veh. Make		Veh. Model		
7 Body Style		<input type="checkbox"/> Pol., Fire, EMS on Emergency (Explain in Narrative if checked)						
8 DL/ID Type		DL/ID State		DL/ID Num.		9 DL Class		
10 CDL End.		11 DL Rest.		DOB (MM/DD/YYYY)				
Address (Street, City, State, ZIP)								
Person Num.		12 Prsn. Type		13 Seat Position		Name: Last, First, Middle		
Enter Driver or Primary Person for this Unit on first line		14 Injury Severity		Age		15 Ethnicity		
16 Sex		17 Eject.		18 Restr.		19 Airbag		
20 Helmet		21 Sol.		22 Alc. Spec.		Alc. Result		
23 Drug Spec.		24 Drug Result		25 Drug Category				
Not Applicable - Alcohol and Drug Results are only reported for Driver/Primary Person for each Unit.								
<input type="checkbox"/> Owner <input type="checkbox"/> Lessee		Owner/Lessee Name & Address						
Proof of Fin. Resp. <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Expired <input type="checkbox"/> Exempt		26 Fin. Resp. Type		Fin. Resp. Name		
Fin. Resp. Phone Num.		27 Vehicle Damage Rating 1		27 Vehicle Damage Rating 2		Vehicle Inventoried <input type="checkbox"/> Yes <input type="checkbox"/> No		
Towed By		Towed To						

DISPOSITION OF INJURED/KILLED	Unit Num.	Prsn. Num.	Taken To	Taken By	Date of Death (MM/DD/YYYY)	Time of Death (24HR:MM)

CHARGES	Unit Num.	Prsn. Num.	Charge	Citation/Reference Num.

DAMAGE	Unit Num.	Prsn. Num.	Damaged Property Other Than Vehicles	Owner's Name	Owner's Address

Unit Num.	<input type="checkbox"/> 10,001+ LBS.	<input type="checkbox"/> TRANSPORTING HAZARDOUS MATERIAL	<input type="checkbox"/> 9+ CAPACITY	CMV Disabling Damage? <input type="checkbox"/> Yes <input type="checkbox"/> No	28 Veh. Oper.	29 Carrier ID Type	Carrier ID Num.
Carrier's Corp. Name			Carrier's Primary Addr.			30 Veh. Type	
31 Bus Type	<input type="checkbox"/> RGWV <input type="checkbox"/> GVWR	HazMat Released <input type="checkbox"/> Yes <input type="checkbox"/> No	32 HazMat Class Num.	HazMat ID Num.	32 HazMat Class Num.	HazMat ID Num.	33 Cargo Body Style
Trailer 1 Unit Num.	<input type="checkbox"/> RGWV <input type="checkbox"/> GVWR	34 Trlr. Type	CMV Disabling Damage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Trailer 2 Unit Num.	<input type="checkbox"/> RGWV <input type="checkbox"/> GVWR	34 Trlr. Type	CMV Disabling Damage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Sequence Of Events	35 Seq. 1	35 Seq. 2	35 Seq. 3	35 Seq. 4			

FACTORS & CONDITIONS	36 Contributing Factors (Investigator's Opinion)				37 Vehicle Defects (Investigator's Opinion)				Environmental and Roadway Conditions					
	Unit #	Contributing	May Have Contrib.		Contributing	May Have Contrib.		38 Weather Cond.	39 Light Cond.	40 Entering Roads	41 Roadway Type	42 Roadway Alignment	43 Surface Condition	44 Traffic Control

NARRATIVE AND DIAGRAM	Investigator's Narrative Opinion of What Happened (Attach Additional Sheets if Necessary)	Indicate North	Field Diagram - Not to Scale

INVESTIGATOR	Time Notified (24HR:MM)	How Notified	Time Arrived (24HRMM)	Report Date (MM/DD/YYYY)
	Invest. Comp. <input type="checkbox"/> Yes <input type="checkbox"/> No	Investigator Name (Printed)	ID Num.	
	ORI Num.	*Agency	Service/Region/DA	

Texas Peace Officer's Crash Report - Code Sheet

Numbered Fields on the CR-3 Refer to the Numbered Lists on this Code Sheet. Each list includes the codes that may be entered on the form and the description of each code.

IDENTIFICATION AND LOCATION	1. Roadway System IH = Interstate TL = Toll Road US = US Highway AL = Alternate SH = State Highway SP = Spur FM = Farm to Market CR = County Road RR = Ranch Road PR = Park Road RM = Ranch to Market PV = Private Road BI = Business Interstate RC = Recreational Road BU = Business US LR = Local Road/Street BS = Business State (Street, Road, Ave., Blvd., Pl., Trl., Beach, Alley, BF = Business FM Boat Ramp, etc.) SL = State Loop		2. Roadway Part 1 = Main/Proper Lane 2 = Service/Frontage Road 3 = Entrance/On Ramp 4 = Exit/Off Ramp 5 = Connector/Flyover 98 = Other (Explain in Narrative)		3. Street Prefix, Direction from Int. or Ref. Marker N = North NE = Northeast E = East SE = Southeast S = South SW = Southwest W = West NW = Northwest		4. Street Suffix RD = Road LOOP = Loop ST = Street EXPY = Expressway DR = Drive CT = Court AVE = Avenue CIR = Circle BLVD = Boulevard PL = Place PKWY = Parkway PARK = Park LN = Lane CV = Cove FWY = Freeway HWY = Highway WAY = Way TRL = Trail				
	5. Unit Description 1 = Motor Vehicle 2 = Train 3 = Pedalcyclist 4 = Pedestrian 5 = Motorized Conveyance 6 = Towed/Trailer 7 = Non-Contact 98 = Other (Explain in Narrative)		6. Vehicle Color BGE = Beige BLK = Black BLU = Blue BRZ = Bronze BRO = Brown CAM = Camouflage CPR = Copper GLD = Gold GRY = Gray GRN = Green MAR = Maroon MUL = Multicolored ONG = Orange PNK = Pink PLE = Purple RED = Red SIL = Silver TAN = Tan TEA = Teal (green) TRQ = Turquoise (blue) WHI = White YEL = Yellow 98 = Other (Explain in Narrative) 99 = Unknown		7. Body Style P2 = Passenger Car, 2-Door P4 = Passenger Car, 4-Door PK = Pickup AM = Ambulance BU = Bus SB = Yellow School Bus FE = Farm Equipment FT = Fire Truck MC = Motorcycle SV = Sport Utility Vehicle PC = Police Car/Truck PM = Police Motorcycle TL = Trailer, Semi-Trailer, or Pole Trailer TR = Truck TT = Truck Tractor VN = Van NEV = Neighborhood Electric Vehicle 98 = Other (Explain in Narrative) 99 = Unknown		8. Driver License/ID Type 1 = Driver License 2 = Commercial Driver Lic. 3 = Occupational 4 = ID Card 5 = Unlicensed 98 = Other 99 = Unknown		9. Driver License Class A = Class A AM = Class A and M B = Class B BM = Class B and M C = Class C CM = Class C and M M = Class M 5 = Unlicensed 98 = Other/Out of State 99 = Unknown		10. Commercial Driver License Endorsements H = Hazardous Materials N = Tank Vehicles P = Passengers S = School Bus T = Double/Triple Trailer X = Tank Vehicle with HazMat 5 = Unlicensed 96 = None 98 = Other/Out of State 99 = Unknown
VEHICLE, DRIVER, AND PERSONS	11. Driver License Restrictions A = With corrective lenses B = LOFS 21 or over C = Daytime only D = Not to exceed 45 MPH E = No expressway driving F = Must hold valid learner lic to MM/DD/YY G = TRC 545.424 applies until MM/DD/YY H = Vehicle not to exceed 26,000 lbs GVWR I = MC not to exceed 250 CC J = Licensed MC operator 21 or over in sight K = Moped L = Vehicle without airbrakes M = CDL intrastate only N = Ignition interlock required O = Occ./Essent. need DL-No CMV-see court order Q = LOFS 21 or over vehicle above Class B R = LOFS 21 or over vehicle above Class C			S = Outside rearview mirror or hearing aid T = Automatic transmission U = Applicable prosthetic device V = Medical variance documentation required W = Power steering X = Vehicle not to exceed Class C Y = Valid TX vision or limb waiver required Z = Applicable vehicle devices P1 = For Class M TRC 545.424 until MM/DD/YY P2 = To/From work/school P3 = To/From work P4 = To/From school P5 = To/From work/school or a LOFS 21 or over P6 = To/from work or LOFS 21 or over P7 = To/from school or LOFS 21 or over P8 = With telescopic lens P9 = LOFS 21 or over bus only P10 = LOFS 21 or over school bus only			P11 = Bus not to exceed 26,000 lbs GVWR P12 = Passenger CMVs restrict to Class C only P13 = LOFS 21 or over in veh equip w/airbrakes P14 = Operation Class B exempt veh authorized P15 = Operation Class A exempt veh authorized P16 = If CMV, school buses interstate P17 = If CMV, government vehicles interstate P18 = If CMV, only trans personal prop interstate P19 = If CMV, trans corpse/sick/injured interstate P20 = If CMV, privately trans passengers interstate P21 = If CMV, fire/rescue interstate P22 = If CMV, intra-city zone drivers interstate P23 = If CMV, custom-harvesting interstate P24 = If CMV, transporting bees/hives interstate P25 = If CMV, use in oil/water well serv/drill P26 = If CMV, for operation of mobile crane P27 = HME expiration date MM/DD/YY P28 = FRSI CDL valid MM/DD/YY to MM/DD/YY P29 = FRSI CDL MM/DD/YY - MM/DD/YY or exempt B veh P30 = FRSI CDL MM/DD/YY - MM/DD/YY or exempt A veh P31 = Class C only - no taxi/bus/emergency veh P32 = Other 5 = Unlicensed 96 = None 98 = Other/Out of State 99 = Unknown				
	12. Person Type 1 = Driver 2 = Passenger/Occupant 3 = Pedalcyclist 4 = Pedestrian 5 = Driver of Motorcycle Type Vehicle 6 = Passenger/Occupant on Motorcycle Type Vehicle 98 = Other (Explain in Narrative) 99 = Unknown		13. Seat Position 1 = Front Left 2 = Front Center 3 = Front Right 4 = Second Seat Left 5 = Second Seat Center 6 = Second Seat Right 7 = Third Seat Left 8 = Third Seat Center 9 = Third Seat Right 10 = Cargo Area 11 = Outside Vehicle 13 = Other in Vehicle 14 = Passenger in Bus 16 = Pedestrian, Pedalcyclist, or Motorized Conveyance 98 = Other (Explain in Narrative) 99 = Unknown								
14. Injury Severity A = Incapacitating Injury B = Non-Incapacitating Injury C = Possible Injury K = Killed N = Not Injured 99 = Unknown		15. Ethnicity W = White B = Black H = Hispanic A = Asian I = Amer. Indian/Alaskan Native 98 = Other 99 = Unknown		16. Sex 1 = Male 2 = Female 99 = Unknown		17. Ejected 1 = No 2 = Yes 3 = Yes, Partial 97 = Not Applicable 99 = Unknown		18. Restraint Used 1 = Shoulder and Lap Belt 2 = Shoulder Belt Only 3 = Lap Belt Only 4 = Child Seat, Facing Forward 5 = Child Seat, Facing Rear 6 = Child Seat, Unknown 7 = Child Booster Seat 96 = None 97 = Not Applicable 98 = Other (Explain in Narrative) 99 = Unknown		19. Airbag 1 = Not Deployed 2 = Deployed, Front 3 = Deployed, Side 4 = Deployed, Rear 5 = Deployed, Multiple 97 = Not Applicable 99 = Unknown	
20. Helmet Use 1 = Not Worn 2 = Worn, Damaged 3 = Worn, Not Damaged 4 = Worn, Unk. Damage 97 = Not Applicable 99 = Unknown if Worn		21. Solicitation Y = Solicit N = No Solicit		22. Alcohol Specimen Type 1 = Breath 2 = Blood 3 = Urine 4 = Refused 96 = None 98 = Other (Explain in Narrative)		27. Vehicle Damage Rating In most cases, enter in the format XX-ABC-Y, where XX is the Direction of Force (1-12), ABC is the Damage Description 2- or 3-letter code, and Y is the Damage Severity (0-7). In special cases, use: VB-1 = vehicle burned, NOT due to collision VB-7 = vehicle catches fire due to the collision TP-0 = top damage only VX-0 = undercarriage damage only MC-1 = motorcycle, moped, scooter, etc. NA = Not Applicable (Farm Tractor, etc.)					
23. Drug Specimen Type 2 = Blood 3 = Urine 4 = Refused 96 = None 98 = Other (Explain in Narrative)		25. Drug Category 2 = CNS Depressants 3 = CNS Stimulants 4 = Hallucinogens 6 = Narcotic Analgesics 7 = Inhalants 8 = Cannabis 10 = Dissociative Anesthetics 11 = Multiple Drugs (Explain in Narrative)		26. Financial Responsibility Type 1 = Liability Insurance Policy 2 = Proof of Liability Insurance 3 = Insurance Binder 4 = Surety Bond 5 = Certificate of Deposit with Comptroller 6 = Certificate of Deposit with County Judge 7 = Certificate of Self-Insurance		24. Drug Test Result 1 = Positive 2 = Negative 97 = Not Applicable 99 = Unknown		25. Drug Category 97 = Not Applicable 98 = Other Drugs (Explain in Narrative) 99 = Unknown			

COMMERCIAL MOTOR VEHICLE	28. Vehicle Operation 1 = Interstate Commerce 2 = Intrastate Commerce 3 = Not in Commerce 4 = Government 5 = Personal	29. Carrier ID Type 1 = US DOT 2 = TxDOT 3 = ICC/MC 96 = None 98 = Other (Explain in Narrative)	30. Vehicle Type 1 = Passenger Car 2 = Light Truck 3 = Bus (9-15) 4 = Bus (>15) 5 = Single Unit Truck 2 Axles 6 Tires 6 = Single Unit Truck 3 or More Axles 7 = Truck Trailer 8 = Truck Tractor (Bobtail) 9 = Tractor/Semi Trailer 10 = Tractor/Double Trailer 11 = Tractor/Triple Trailer 98 = Other (Explain in Narrative) 99 = Unknown Heavy Truck	31. Bus Type 0 = Not a Bus 1 = School (Public or Private) 2 = Transit 3 = Intercity 4 = Charter 5 = Other 6 = Shuttle 9 = Not Reported/Unknown	32. Hazardous Material Class Number 1 = Explosives 2 = Gases 3 = Flammable Liquids 4 = Flammable Solids 5 = Oxidizers and Organic Peroxides 6 = Toxic Materials and Infectious Substances 7 = Radioactive Materials 8 = Corrosive Materials 9 = Miscellaneous Dangerous Goods
	33. Cargo Body Style 1 = Bus (9-15) 2 = Bus (>15) 3 = Van/Enclosed Box 4 = Cargo Tank 5 = Flatbed 6 = Dump 7 = Concrete Mixer	8 = Auto Transporter 9 = Garbage Refuse 10 = Grain Chips Gravel 11 = Pole 13 = Intermodal 14 = Logging	15 = Vehicle Towing Another Vehicle 97 = Not Applicable 98 = Other (Explain in Narrative)	34. Trailer Type 1 = Full Trailer 2 = Semi-Trailer 3 = Pole Trailer	
FACTORS AND CONDITIONS	35. Sequence of Events 1 = Non-Collision: Ran Off Road 2 = Non-Collision: Jackknife 3 = Non-Collision: Overturn Rollover 4 = Non-Collision: Downhill Runaway 5 = Non-Collision: Cargo Loss Or Shift 6 = Non-Collision: Explosion Or Fire 7 = Non-Collision: Separation of Units 8 = Non-Collision: Cross Median/Centerline 9 = Non-Collision: Equipment Failure 10 = Non-Collision: Other 11 = Non-Collision: Unknown 12 = Collision Involving Pedestrian 13 = Collision Involving Motor Vehicle in Transport 14 = Collision Involving Parked Motor Vehicle 15 = Collision Involving Train 16 = Collision Involving Pedalcycle 17 = Collision Involving Animal 18 = Collision Involving Fixed Object 19 = Collision With Work Zone Maintenance Equipment 20 = Collision With Other Movable Object 21 = Collision With Unknown Movable Object 98 = Other (Explain in Narrative)				
	36. Factors and Conditions 1 = Animal on Road - Domestic 2 = Animal on Road - Wild 3 = Backed without Safety 4 = Changed Lane when Unsafe 14 = Disabled in Traffic Lane 15 = Disregard Stop and Go Signal 16 = Disregard Stop Sign or Light 17 = Disregard Turn Marks at Intersection 18 = Disregard Warning Sign at Construction 19 = Distraction in Vehicle 20 = Driver Inattention 21 = Drove Without Headlights 22 = Failed to Control Speed 23 = Failed to Drive in Single Lane 24 = Failed to Give Half of Roadway 25 = Failed to Heed Warning Sign 26 = Failed to Pass to Left Safely 27 = Failed to Pass to Right Safely 28 = Failed to Signal or Gave Wrong Signal 29 = Failed to Stop at Proper Place 30 = Failed to Stop for School Bus 31 = Failed to Stop for Train 32 = Failed to Yield ROW - Emergency Vehicle 33 = Failed to Yield ROW - Open Intersection 34 = Failed to Yield ROW - Private Drive 35 = Failed to Yield ROW - Stop Sign 36 = Failed to Yield ROW - To Pedestrian 37 = Failed to Yield ROW - Turning Left 38 = Failed to Yield ROW - Turn on Red 39 = Failed to Yield ROW - Yield Sign 40 = Fatigued or Asleep 41 = Faulty Evasive Action 42 = Fire in Vehicle 43 = Fleeing or Evading Police 44 = Followed Too Closely 45 = Had Been Drinking 46 = Handicapped Driver (Explain in Narrative) 47 = Ill (Explain in Narrative) 48 = Impaired Visibility (Explain in Narrative) 49 = Improper Start from Parked Position 50 = Load Not Secured 51 = Opened Door Into Traffic Lane 52 = Oversized Vehicle or Load 53 = Overtake and Pass Insufficient Clearance 54 = Parked and Failed to Set Brakes 55 = Parked in Traffic Lane 56 = Parked without Lights 57 = Passed in No Passing Lane 58 = Passed on Right Shoulder 59 = Pedestrian FTYROW to Vehicle 60 = Unsafe Speed 61 = Speeding - (Over Limit) 62 = Taking Medication (Explain in Narrative) 63 = Turned Improperly - Cut Corner on Left 64 = Turned Improperly - Wide Right 65 = Turned Improperly - Wrong Lane 66 = Turned when Unsafe 67 = Under Influence - Alcohol 68 = Under Influence - Drug 69 = Wrong Side - Approach or Intersection 70 = Wrong Side - Not Passing 71 = Wrong Way - One Way Road 73 = Road Rage 74 = Cell/Mobile Device Use - Talking 75 = Cell/Mobile Device Use - Texting 76 = Cell/Mobile Device Use - Other 77 = Cell/Mobile Device Use - Unknown 98 = Other (Explain in Narrative)				
FACTORS AND CONDITIONS	37. Vehicle Defects 5 = Defective or No Headlamps 6 = Defective or No Stop Lamps 7 = Defective or No Tail Lamps 8 = Defective or No Turn Signal Lamps 9 = Defective or No Trailer Brakes 10 = Defective or No Vehicle Brakes 11 = Defective Steering Mechanism 12 = Defective or Slick Tires 13 = Defective Trailer Hitch 98 = Other (Explain in Narrative)	38. Weather Condition 1 = Clear 2 = Cloudy 3 = Rain 4 = Sleet/Hail 5 = Snow 6 = Fog 7 = Blowing Sand/Snow 8 = Severe Crosswinds 98 = Other (Explain in Narrative) 99 = Unknown	39. Light Condition 1 = Daylight 2 = Dark, Not Lighted 3 = Dark, Lighted 4 = Dark, Unknown Lighting 5 = Dawn 6 = Dusk 98 = Other (Explain in Narrative) 99 = Unknown	40. Entering Roads 2 = Three Entering Roads - T 3 = Three Entering Roads - Y 4 = Four Entering Roads 5 = Five Entering Roads 6 = Six Entering Roads 7 = Traffic Circle 8 = Cloverleaf 97 = Not Applicable 98 = Other (Explain in Narrative)	
	41. Roadway Type 1 = Two-Way, Not Divided 2 = Two-Way, Divided, Unprotected Median 3 = Two-Way, Divided, Protected Median 4 = One-Way 98 = Other (Explain in Narrative)	42. Roadway Alignment 1 = Straight, Level 2 = Straight, Grade 3 = Straight, Hillcrest 4 = Curve, Level 5 = Curve, Grade 6 = Curve, Hillcrest 98 = Other (Explain in Narrative) 99 = Unknown	43. Surface Condition 1 = Dry 2 = Wet 3 = Standing Water 4 = Snow 5 = Slush 6 = Ice 7 = Sand, Mud, Dirt 98 = Other (Explain in Narrative) 99 = Unknown	44. Traffic Control 2 = Inoperative (Explain in Narrative) 3 = Officer 4 = Flagman 5 = Signal Light 6 = Flashing Red Light 7 = Flashing Yellow Light 8 = Stop Sign 9 = Yield Sign 10 = Warning Sign	11 = Center Stripe/Divider 12 = No Passing Zone 13 = RR Gate/Signal 15 = Crosswalk 16 = Bike Lane 17 = Marked Lanes 18 = Signal Light With Red Light Running Camera 96 = None 98 = Other (Explain in Narrative)

AREA OF IMPACT

[Empty box for area of impact]

ROADWAY WIDTH'S

N/S ROADWAY _____
 NO. TRAFFIC LANES _____
 E/W ROADWAY _____
 NO. TRAFFIC LANES _____

SKID MARKS

1.
 To Impact _____
 From Impact _____
 2.
 To Impact _____
 From Impact _____

WITNESS NAME

ADDRESS

HOME PHONE

WORK PHONE

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

WITNESS DESCRIPTION OF WHAT HAPPENED:

DRIVER'S DESCRIPTION OF WHAT HAPPENED:

Justification _____

Accounting Information:									
Fund	Dept:	Unit:	Sub Unit:	Object, Revenue, or BSA:	Activity:	Function:	Reporting:	Task Order (or other Program/Program Period for Grants):	Amount
xxxx (4)	xxxx (4)	xxxx (4)	xx (2)	xxxx (4)	xxxx (4)	xxxx (4)	xxxx (4)	xxxxxxxxxx (10)	

Custodian Signature: _____ Printed name: _____

Reimb To Signature: _____ Printed name: _____

Receipt must accompany this reimbursement. Reimbursement will not be made if more than \$150.00. A reimbursement must replace an Advance within 3 business days.

FIN9074 R 07 08 White- Reimbursement Request Canary- Recipient Pink- Retain

**City Of Austin
Petty Cash Reimbursement/Advance**

PC

Date _____ Department: _____ Amount: _____

Vendor name, if advance write "Advance" _____

For Advance replacement ID Number

Items Purchased: _____

Justification _____

Accounting Information:									
Fund	Dept:	Unit:	Sub Unit:	Object, Revenue, or BSA:	Activity:	Function:	Reporting:	Task Order (or other Program/Program Period for Grants):	Amount
xxxx (4)	xxxx (4)	xxxx (4)	xx (2)	xxxx (4)	xxxx (4)	xxxx (4)	xxxx (4)	xxxxxxxxxx (10)	

Custodian Signature: _____ Printed name: _____

Reimb To Signature: _____ Printed name: _____

Receipt must accompany this reimbursement. Reimbursement will not be made if more than \$150.00. A reimbursement must replace an Advance within 3 business days.

FIN9074 R 07 08 White- Reimbursement Request Canary- Recipient Pink- Retain

**City Of Austin
Petty Cash Reimbursement/Advance**

PC

Date _____ Department: _____ Amount: _____

Vendor name, if advance write "Advance" _____

For Advance replacement ID Number

Items Purchased: _____

Justification _____

Accounting Information:									
Fund	Dept:	Unit:	Sub Unit:	Object, Revenue, or BSA:	Activity:	Function:	Reporting:	Task Order (or other Program/Program Period for Grants):	Amount
xxxx (4)	xxxx (4)	xxxx (4)	xx (2)	xxxx (4)	xxxx (4)	xxxx (4)	xxxx (4)	xxxxxxxxxx (10)	

Custodian Signature: _____ Printed name: _____

Reimb To Signature: _____ Printed name: _____

**CITY OF AUSTIN, TEXAS
RECEIPT FOR PAYMENT OF FUNDS**

NO. 23900281

DATE RECEIVED: _____
 RECEIVED FROM: _____ \$ _____
 IN PAYMENT FOR: _____
 *AMOUNT VERIFIED BY: _____ CITY OF AUSTIN, TEXAS

XXXXXX	FUND	AGENCY	ORG	SUB ORG	ACTV	REV/ OBJT	WORKORDER	REPT CATG	B/S ACCT	AMOUNT
HOW PAID:	XXX	XXX	XXXX	XX	XXXX	XXXX	XXXXXXXXXX	XXXX	XXXX	XXXXXX
CASH <input type="checkbox"/>										
CHECK <input type="checkbox"/>										
MONEY ORDER <input type="checkbox"/>										

FIN 7026 Rev 7/90 DEPARTMENT AUTHORIZED SIGNATURE
 WHITE - Finance YELLOW - Dept PINK - Employee GOLD - Dept. File

**CITY OF AUSTIN, TEXAS
RECEIPT FOR PAYMENT OF FUNDS**

NO. 23900282

DATE RECEIVED: _____
 RECEIVED FROM: _____ \$ _____
 IN PAYMENT FOR: _____
 *AMOUNT VERIFIED BY: _____ CITY OF AUSTIN, TEXAS

XXXXXX	FUND	AGENCY	ORG	SUB ORG	ACTV	REV/ OBJT	WORKORDER	REPT CATG	B/S ACCT	AMOUNT
HOW PAID:	XXX	XXX	XXXX	XX	XXXX	XXXX	XXXXXXXXXX	XXXX	XXXX	XXXXXX
CASH <input type="checkbox"/>										
CHECK <input type="checkbox"/>										
MONEY ORDER <input type="checkbox"/>										

FIN 7026 Rev 7/90 DEPARTMENT AUTHORIZED SIGNATURE
 WHITE - Finance YELLOW - Dept PINK - Employee GOLD - Dept. File

**CITY OF AUSTIN, TEXAS
RECEIPT FOR PAYMENT OF FUNDS**

NO. 23900283

DATE RECEIVED: _____
 RECEIVED FROM: _____ \$ _____
 IN PAYMENT FOR: _____
 *AMOUNT VERIFIED BY: _____ CITY OF AUSTIN, TEXAS

XXXXXX	FUND	AGENCY	ORG	SUB ORG	ACTV	REV/ OBJT	WORKORDER	REPT CATG	B/S ACCT	AMOUNT
HOW PAID:	XXX	XXX	XXXX	XX	XXXX	XXXX	XXXXXXXXXX	XXXX	XXXX	XXXXXX
CASH <input type="checkbox"/>										
CHECK <input type="checkbox"/>										
MONEY ORDER <input type="checkbox"/>										

FIN 7026 Rev 7/90 DEPARTMENT AUTHORIZED SIGNATURE
 WHITE - Finance YELLOW - Dept PINK - Employee GOLD - Dept. File

**CITY OF AUSTIN, TEXAS
RECEIPT FOR PAYMENT OF FUNDS**

NO. 23900284

DATE RECEIVED: _____
 RECEIVED FROM: _____ \$ _____
 IN PAYMENT FOR: _____
 *AMOUNT VERIFIED BY: _____ CITY OF AUSTIN, TEXAS

XXXXXX	FUND	AGENCY	ORG	SUB ORG	ACTV	REV/ OBJT	WORKORDER	REPT CATG	B/S ACCT	AMOUNT
HOW PAID:	XXX	XXX	XXXX	XX	XXXX	XXXX	XXXXXXXXXX	XXXX	XXXX	XXXXXX
CASH <input type="checkbox"/>										
CHECK <input type="checkbox"/>										
MONEY ORDER <input type="checkbox"/>										

FIN 7026 Rev 7/90 DEPARTMENT AUTHORIZED SIGNATURE
 WHITE - Finance YELLOW - Dept PINK - Employee GOLD - Dept. File

**CITY OF AUSTIN
PAYMENT RECEIPT**



DEPARTMENT: _____

DATE RECEIVED: _____

RECEIVED FROM: _____

FORM OF PAYMENT:

CASH **CHECK** **MONEY ORDER**

_____ **AMOUNT: \$** _____

IN PAYMENT FOR: _____

ACCOUNT NUMBER: _____

AUTHORIZED SIGNATURE: _____ **CASHIER:** _____

City Of Austin
Petty Cash Reimbursement/Advance

For Approvals

Date: _____ Department: _____ Amount: _____

Vendor name, if advance write "Advance": _____

Items Purchased: _____

Justification _____

Accounting Information:

Fund:	Dept:	Unit:	Sub Unit:	Object, Revenue, or BSA:	Activity:	Function:	Reporting:	Task Order (or other Program/Program Period for Grants):	Amount
xxxx (4)	xxxx (4)	xxxx (4)	xx (2)	xxxx (4)	xxxx (4)	xxxx (4)	xxxx (4)	xxxxxxxxxx (10)	

Approval Signature: _____ Printed name: _____

Reimb. To Signature: _____ Printed name: _____

Receipt must accompany this reimbursement. Reimbursement will not be made if more than \$150.00. A reimbursement must replace an Advance within 3 business days.

USE BALL POINT PEN • PRESS HARD – YOU ARE MAKING 3 COPIES • WRITE ON HARD SURFACE



DRIVER'S VEHICLE CONDITION REPORT

(Pre-Trip/Post/Trip Inspection Report)

DATE: _____ UNIT#: _____ LICENSE#: _____

DRIVER'S NAME (PRINT): _____ DEPT: _____

CONTACT NAME (PRINT): _____ PHONE #: _____

Exceeds Dot 396.11 And 396.13 Requirements

Pre-Trip Mileage: _____

Post-Trip Mileage: _____

For every item that applies to your vehicle place a check in the appropriate box. Explain NO items in remarks.

EXTERIOR & ENGINE COMPARTMENT

	PRE		POST		N/A
	OK	NO	OK	NO	
1. Air Lines, Electrical Cords	<input type="checkbox"/>				
2. All Exterior Lights & Reflectors	<input type="checkbox"/>				
3. Battery, Cables & Mounting	<input type="checkbox"/>				
4. Belts, Hoses & Wiring	<input type="checkbox"/>				
5. Body Condition – Damage	<input type="checkbox"/>				
6. Coolant Level & Condition	<input type="checkbox"/>				
7. Drive Line & Frame	<input type="checkbox"/>				
8. Engine Oil Level & Condition	<input type="checkbox"/>				
9. Exhaust System	<input type="checkbox"/>				
10. Fifth Wheel, Latch, Trailer Pin	<input type="checkbox"/>				
11. Front & Rear Axles, Steering Box	<input type="checkbox"/>				
12. Other Fluid Levels & Condition	<input type="checkbox"/>				
13. Springs, Shackles, Shocks	<input type="checkbox"/>				
14. Check brake lining condition	<input type="checkbox"/>				
15. Check slack adjuster condition	<input type="checkbox"/>				
16. Check hardware on brake pods	<input type="checkbox"/>				
17. Tires, Wheels, Lugs & Pressure	<input type="checkbox"/>				
18. Wheel Flaps & Skirts	<input type="checkbox"/>				
19. Windows, Wipers, Mirrors	<input type="checkbox"/>				
SAFETY EQUIPMENT					
20. Collision Report Kit	<input type="checkbox"/>				
21. Exposure Control Kit	<input type="checkbox"/>				
22. Fire Extinguisher Charge Date	<input type="checkbox"/>				
23. First Aid Kit	<input type="checkbox"/>				
24. Flares, Red Reflective Triangles	<input type="checkbox"/>				
25. Spare Fuses	<input type="checkbox"/>				

INTERIOR

	PRE		POST		N/A
	OK	NO	OK	NO	
26. Air Loss Within Limits – See Reverse	<input type="checkbox"/>				
27. Air Brake Warning Below 60PSI	<input type="checkbox"/>				
28. Air Brake Working PSI 110-120	<input type="checkbox"/>				
29. Gauges: Air, Oil, Charging System	<input type="checkbox"/>				
30. Heater, Defroster, Air Conditioner	<input type="checkbox"/>				
31. Horn, Interior Lights	<input type="checkbox"/>				
32. Hydraulic Brakes 50% Pedal	<input type="checkbox"/>				
33. Seats, Seat Belts, Mounting	<input type="checkbox"/>				
34. Warning Lights & Buzzers	<input type="checkbox"/>				

TRAILER

	PRE		POST		N/A
	OK	NO	OK	NO	
35. Brake Connections	<input type="checkbox"/>				
36. Coupling Chains	<input type="checkbox"/>				
37. Exterior Condition	<input type="checkbox"/>				
38. Frame, Cross members, Rails	<input type="checkbox"/>				
39. Hitch/Fifth Wheel	<input type="checkbox"/>				
40. Landing Gear	<input type="checkbox"/>				
41. Lights Reflectors	<input type="checkbox"/>				
42. Springs, Shackles	<input type="checkbox"/>				
43. Tarpaulin, Tiedowns	<input type="checkbox"/>				
44. Tires, Wheels, Lugs & Pressure	<input type="checkbox"/>				

Unit No. _____

STATE INSPECTION DUE

DATE:

Operational components clear of debris Yes or No _____

Excess weight cleared/removed from vehicles Yes or No _____

MECH SIGN/DATE	REMARKS

- Above Defects Have Been Corrected
- Above Defects Do Not Require Correction At This Time
- No Defects Found – Truck/Tractor Unit
- No Defects Found – Trailer Unit

DRIVER'S SIGNATURE INDICATES THE CONDITION OF THE UNIT IS SATISFACTORY

Driver's Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____

WHITE: Vehicle/Operator

YELLOW: Service Center

PINK: Operating Department

DVR-1000 Revised: 5/8/2009

INSTRUCTIONS FOR DRIVER'S VEHICLE CONDITION REPORT

The driver is ultimately responsible for making sure the vehicle is safe to operate.

*The driver is in the best position to detect vehicle deficiencies and to refer them for repairs.
Inspection procedures and reports assist in preventing failures from occurring while the vehicle is being operated.*

Air Loss shall be checked with engine off. Air loss shall be less than 2 psi/min without brake applied (3 psi/min with trailer attached). With brake applied, air loss shall be less than 3 psi/min (4 psi/min with trailer attached).

Air Lines, Electrical Cords shall be checked for air leaks and inspected to ensure that hoses are not cut, chafed or worn and lines are not pinched or dragging.

Battery, Cables & Mounting shall be snug, with no leaks, and tied down properly. *(Report any signs of corrosion)*

Belts, Hoses and Wiring such as power steering, water pump, alternator, air compressor (if available) belts, shall be checked for proper belt tension (up to 3/4-in. play at center of belt), cracks or frayed places.

Body Condition shall be checked and any body damage must be noted on the condition report - dents, scratches, broken or missing parts, mirrors, etc.

Coolant Level shall be checked with engine OFF, using the sight glass or by removing radiator cap to check the visible coolant level. *(Never remove the radiator cap from an engine that is at operating temperature.)*

Drive Line & Frame shall be checked for cracked, broken or sagging frame members and loose or missing fasteners that may attach functional components.

Engine Oil Level & Condition shall be checked with the engine OFF. To ensure that the oil level is within safe operating range, the engine shall be stopped for at least 3 minutes before checking. Only add oil if the level is below the add line.

Exhaust System shall be checked for any exhaust system parts that are leaking, loose broken or missing exhaust pipes, mufflers, tailpipes or stacks, broken or missing mounting brackets, clamps, bolts or nuts.

Exterior Lights and Reflectors must be clean and functional. Verify headlights, (both high and low beam), taillights, turn signals brake lights, and flashers all operate properly. Ensure that reflectors are not missing or broken (red on rear, amber elsewhere).

Front & Rear Axles, Steering Box shall be checked with the engine running. Look for power steering fluid leaks, and check for excessive play in the steering wheel. (Play shall not exceed 2 inches before left front wheel begins to move).

Gauges, Oil, Air, Charging System indicators shall be checked with the engine running. Start engine - note gauge readings, (oil pressure, temperature, fuel gauge, alternator charging rate) (note low air pressure indicator).

Heater, Defroster, Air Conditioning shall be checked to ensure that all are in working order.

Horn, Interior Warning Lights & Buzzers shall be checked to ensure that the air horn/electric horn functions properly, the back-up alarm is working, and that all dashboard indicators are working - turn indicators, 4-way flashers, headlights (high & Low beam), fluid warning lights, low air pressure warning, etc.

Other Fluid Levels & Condition such as power steering fluid and wiper fluid shall be in appropriate range.

Safety Equipment must be verified to include a charged fire extinguisher and flares or reflective triangles.

Springs, Shackles, Shocks shall be checked for broken leaf or coil springs, and shocks shall be secure with no leaks.

Tires, Wheels, Lugs & Pressure inspect tires for proper air pressure (use gauge), cuts or other damage to tread or sidewalls, tread separation, cut, cracked or missing valve stems, and tread wear - at least 4/32 on front tires, 2/32 on other tires.

Wheel Flaps & Skirts shall not be missing or damaged and they must be mounted securely.

Wheels and Rims shall not be missing clamps, spacers, studs or lugs, have rust around wheel nuts (may mean the nuts are loose - check tightness), or have cracked or bent lock rings.

Windows, Wipers, and Mirrors shall be inspected for any crack more than 1/4 in. long or 3/8 in. in diameter; dirt, stickers or other obstructions to seeing, or any inoperative or damaged windshield wiper power unit. Mirrors shall be clean and properly adjusted from INSIDE the vehicle.

NO ACTION VCRs: The Texas DPS (Department of Public Safety) requests that the previous day's completed post-trip VCR along with the current day's completed pre-trip VCR inspection report be kept in the vehicle. Operating Departments must keep on file, by unit number, VCRs from two to 90 days old. City Departments will recycle all VCRs older than 90 days.

REPAIRS REQUIRED VCRs: Operators are required to give the Service Writer or Supervisor the WHITE (Vehicle/Operator), and the YELLOW (Service Center) copies of a completed VCR when the operator leaves a unit at a Service Center for repairs. After the vehicle is checked out and/or repaired, the mechanic performing the checkout or repair, checks the appropriate box, signs the WHITE and YELLOW Copies, and places the WHITE Copy back in the unit to communicate the outcome of the repair to the driver. The mechanic gives the YELLOW Copy to the Supervisor for filing in the Service Center maintenance file. After the unit is back in service, the driver turns in the signed WHITE Copy to his or her Supervisor for filing in the departmental file. Departments file the PINK (Operating Department) copies that are two to 90 days old, by unit number. City Departments will recycle all VCRs older than 90 days.

SERVICE WRITERS/SUPERVISORS will ask all operators to complete a thorough inspection of their unit and to document the results of the inspection on the VCR before accepting the unit for maintenance or repair.

SERVICE CENTER SUPERVISORS will review the driver's remarks on the VCR and mechanic's actions to correct the identified problems before closing the work order and filing the YELLOW Service Center Copy in the maintenance file. Service Centers will recycle all VCRs older than 90 days.

WHITE: Vehicle/Operator

YELLOW: Service Center

PINK: Operating Department

Revised: 5/8/2009

COLLISION REPORT KIT

THE CITY OF AUSTIN IS SELF-INSURED AGAINST CLAIMS OF LIABILITY. ACCORDING TO SECTION 601.007 OF THE TEXAS TRANSPORTATION CODE, THE “MOTOR VEHICLE SAFETY RESPONSIBILITY ACT” DOES NOT APPLY TO GOVERNMENT VEHICLES OR GOVERNMENT EMPLOYEES OPERATING THOSE VEHICLES EXCEPT AS SPECIFIED IN SECTION 601.004, ACCIDENT REPORTS; SECTION 601.54, OWNER PROVIDED FINANCIAL RESPONSIBILITY; AND CHAPTER 643, MOTOR CARRIER REGISTRATION.



**CITY MANAGER
P.O. BOX 1088
AUSTIN, TEXAS 78767**



Think safety!

Use the following procedure whenever a collision occurs:

Stop and check for injuries

All collisions must be reported to 911, your supervisor, and department safety immediately

For everyone's safety, unless there is an injury, move your vehicle and use warning markers, if available

Exchange the information form with the other driver and complete collision report

Talk only with the police and city officials about the collision

Your collision report form should be completed and turned in to your supervisor within 24 hours



City of Austin Vehicle Collision Report

DRIVER'S REPORT

Dept. Collision # _____
Dept. Division # _____

I. Date of Collision _____ Time _____ am / pm Day of the Week _____
 Location of Collision _____ Posted Speed Limit _____ MPH

II. City Driver and Vehicle

Driver's Name _____	Driver's License # _____
Employee # _____ Job Title _____	CDL Yes / No _____ Class A B C
City Dept. _____ Work Location _____	Work Phone _____
Seat Belt Used? Yes / No _____	Driver Hurt? Yes / No _____
Vehicle Make _____	Vehicle Model _____
City Vehicle # _____	License Plate # _____
Started Work at _____ am/pm	# Years Driving _____
Other People in the Vehicle:	Vehicle Damaged? Yes / No _____
Name _____	Vehicle Inspection done? Yes/No _____
Name _____	Job Title _____
	Hurt? Yes / No _____
	Job Title _____
	Hurt? Yes / No _____

III. Other Driver and Vehicle

Driver's Name _____ Address _____ Phone # _____
 Driver's License # _____ Class _____ Driver Hurt? Yes / No _____
 Vehicle Make/Model _____ Vehicle Year _____ Color _____ License Plate # _____
 Owner's Name _____ Address _____ Phone # _____
 Insurance? Yes / No Insurance Company Name _____ Policy # _____
 Vehicle Damaged? Yes / No Describe _____
 Other Passengers:
 Name _____ Address _____ Hurt? Yes / No _____

IV. Other Damage

What was damaged? _____ Description of damage _____
 Owner's Name _____ Address _____ Phone # _____

V. Witness Information

Name _____ Address _____ Phone # _____
 Name _____ Address _____ Phone # _____

VI. Conditions at the Time of the Collision

A. Where were you driving?

- On City Property
- On a Public Street
- Off-Road (ditch, shoulder, field, etc.)
- Other:

C. Weather Conditions

- Sunny/dry
- Rain
- Fog
- Hail
- Wind
- Other:

E. Visibility

- No problems
- Blinding light
- Foreign object in eye
- Curve in road
- Hill or dip in road
- Change in road width
- Other:

G. Vehicle

- No problems
- Mechanical problems
- Electrical problems
- Air pressure problems
- Part problems
- Tire problems
- Brake failure
- Other problems:

B. What were you doing?

- Backing up
- Driving in traffic
- Slowing down to stop
- Parking
- Start from stop
- Crossing intersection
- Turning
- Passing
- Other:

D. Road Conditions

- Light traffic
- Heavy traffic
- Muddy road
- Sand or gravel
- Other things on the road
- Unpaved road
- Slippery surface
- Other:

F. Type of Road

- One way traffic
- Exit/Entrance ramp
- Divided highway
- Undivided highway
- Number of lanes _____

H. Police officer's name:

 Police officer's badge #: _____

 Police Report # _____

I. In your opinion, was the vehicle safe to drive before the collision? Yes / No If no, did you tell your supervisor? Yes / No

J. Have you been trained to use this vehicle? Yes / No

EXCHANGE OF INFORMATION FORM #1
(Attach to the City of Austin Vehicle Collision Report Form)

NOTE FOR THE CITY DRIVERS: Please obtain the following information from the other driver involved in the collision. Use this information to complete the City of Austin Vehicle Collision Report Form and turn both completed forms into your supervisor.

Other Driver's Name: _____ Date: _____ Time: _____

Other Driver's License #: _____ Phone#: _____

Vehicle License #: _____ Make of Vehicle: _____ Type: _____

Address: _____ City _____ State _____ Zip _____

Vehicle Owner's Name: _____ Phone#: _____

Vehicle Owner's Address: _____

Insurance Company's Name: _____ Phone#: _____

Witness's Name: _____ Phone#: _____

(Use back of card for additional witness names or information)

TEAR ON DOTTED LINE

TEAR ON DOTTED LINE



CITY OF AUSTIN, TEXAS
COLLISION EXCHANGE OF INFORMATION FORM #2

(This card is to be completed by the City driver and given to the other vehicle driver).

City Driver Name: _____ Date: _____ Time: _____

Department Name: _____ Division Name: _____

City Vehicle #: _____ License Plate #: _____ Make/Type: _____

Location of Collision: _____

NOTE: If a police officer's report was prepared for this collision, it may be obtained at the Police Department for a nominal fee within 72 hours of the collision. Any questions concerning damages to persons or property, resulting from this collision should be directed to the City's Law Department at (512) 974-2268

Thank you for your cooperation,

Human Resources Safety and Workers' Compensation Division

VII. Tell how the collision happened and draw a picture below. (Use another piece of paper if more space needed).

Draw

Write

Driver's Signature _____ Date Completed _____ Date given to supervisor _____

SUPERVISOR'S REPORT

Is there any other information that should be added to this report? Yes/No If yes, please explain

Were the police called? Yes/No Did they report to the scene? Yes/No Police report completed? Yes / No
 Were any tickets given? Yes / No To whom and for what? _____
 Did you call the safety office? Yes/No When? Date _____ Time _____ am/pm
 Any vehicle towed? Yes/No Injuries treated away from scene? Yes/No
 What was the main cause of the collision?

What could the driver have done differently to avoid the collision?

Is there anything that you can do to help prevent this type of collision from happening again?

Police report attached to this report? Yes / No

Vehicle Inspection checklist attached to this report? Yes/No

Supervisor's Signature _____ Date _____ Phone # _____

Date Sent to Dept Safety _____ Date Received by Dept Safety _____

DEPARTMENT SAFETY REPRESENTATIVE'S REPORT

IA. Has this driver had any other on the job collisions:

1. in the past year? Yes / No 2. in the past 3 years? Yes / No

IB. Has this driver had a driver training

course within the last 3 yrs? Yes / No

II. What is the major contributing factor of this collision?

A Supervisor actions:

- Failed to correct pre-existing hazard
- Directed/allowed use of unsafe vehicle

B Driver actions:

- Unsafe backing
- Speed unsafe for conditions
- Following too closely
- Misjudgement right
- Misjudgement left
- Improper equipment operation
- Failure to yield right of way
- Lost control
- Misjudgement top
- Distraction/inattention
- No fault of driver
- Other :

III. RECOMMENDATION: NCI Non Preventable A B Preventable C D E Points _____

Corrective/Preventive Recommendations _____

Department Safety Representative's Signature _____ Date _____ Phone # _____

VEHICLE OR EQUIPMENT STATUS NOTICE

(Only Appropriate Items Need Be Completed)

MGT. CODE _____ UNIT NO. _____ DEPT. _____ DATE _____ EFFECTIVE DATE _____

TYPE OF ACTION

VEHICLE INFORMATION

____ Turned In
____ Dormant for Disposal
____ Dormant for Reuse
____ Transfer to Dept _____
____ Transfer to Account _____
____ Replacement _____
____ Charge Mgt. Code to _____

Current Mileage / Hours _____
License Number _____
Account Number _____
Fuel Card Number _____
VIN# _____

Remarks: _____

Print

Owning/Receiving Department Signature Date

Print

Vehicle Support/Services Signature Date

WHITE COPY:	V.S.S	YELLOW COPY:	Fuel OPS	PINK COPY:	Dept
-------------	-------	--------------	----------	------------	------

Austin Fire Department Cost Recovery Notification Form

For information contact: **Austin Fire Department Special Operations**
Office (512)974-4160 Fax (512)974-4165

AFD Incident # (8 digit number)

On-scene Owner's Representative:

Name: _____

Driver's License#: _____ DOB: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Signature: _____

Bill To:

Name (Owner/Mgr.): _____

Business Address: _____

City: _____ State: _____ Zip: _____

Phone #: (_____) _____

Vehicle License # & State: _____

Item	Quantity	Unit /Size	Unit Price (\$)	Total (\$)
PERSONAL PROTECTIVE EQUIP.				
LEVEL A				
Level A		Each	1100.00	
LEVEL B				
Decon		Each	100.00	
Entry		Each	175.00	
Level B Encap.		Each	330.00	
Tyvek Coveralls		Each	6.75	
Specialized Suit		Each		
GLOVES				
Neoprene		Pair	6.75	
Butyl		Pair	40.00	
Viton		Pair	160.00	
Nitrile		Pair	4.25	
Silver Shield		Pair	10.00	
Kevlar		Pair	7.00	
Cowhide Gloves		Pair	10.00	
BOOTS				
Chemical Boot		Pair	65.00	
Boot Covers		Pair	7.00	
TURNOUT GEAR				
Coat		Each	1007.00	
Pants		Each	753.00	
Helmet		Each	172.00	
Boots		Each	100.00	
Goggles		Each	7.00	
Winter Coat		Each	67.50	
Gloves		Each	55.00	
NEUTRALIZER				
Sodium Bicarb		50#	11.00	
Hydrated Lime		50#	11.00	
Subtotal 1				

Item	Quantity	Unit /Size	Unit Price (\$)	Total (\$)
ABSORBENT				
Clay Bags		50#	5.85	
H.O.W. Boom/Socks				
8" x 10'		Each	62.00	
5" x 10'		Each	55.00	
3"x4' Socks		Each	7.50	
H.O.W. PADS				
36" x34"		Each	4.00	
18" x 18"		Each	0.70	
DRUMS				
Open-Head Steel		55 gal	120.00	
Closed-Head Steel		55 gal	110.00	
Metal Salvage		85 gal	167.00	
Poly Overpak		95 gal	250.00	
Poly Lab Pak		20 gal	70.00	
PUMPS				
Drum Pump - HC		Each	62.00	
Drum Pump - Acid		Each	62.00	
Short Hand Pump		Each	34.00	
DECON				
Portable Kit		Kit	1000.00	
Drip Pool		Each	10.00	
Poly Drip Tarp		15x20	36.00	
Collaps. Decon Pool		Each	290.00	
MISC.				
Poly Pail w/ Lid		5 gal.	10.30	
Univ. Gold B Foam		1 gal	26.00	
Hole Saw		4"	32.50	
Expanding plug		4"	10.00	
Expanding Ftball		each	60.00	
Subtotal 2				

Comments:

Note: In accordance with UFC 80.104 part C, the Austin Fire Department is authorized to bill for materials and personnel cost incurred at Hazardous Materials Incidents. The balance indicated should be remitted to the address listed below.

Make checks payable to: Austin Fire Department	Austin Fire Department Attn: Accounts Receivable 4201 Ed Bluestein Blvd. Austin, TX 78721
--	--

TOTAL DUE (Subtotal 1 + Subtotal 2)	Date:
\$ _____	_____

Incident Commander: _____ TXFR _____

AFD Witness: _____ TXFR _____





IMPORTANT NOTICE



IMPORTANT NOTICE

Balance Due:

*The balance on your account is due and requires immediate attention.
We are anxious to help resolve your balance.*

This account is eligible to be transferred to our collection company for further processing in 30 days. We use our collection company as a last resort and do not want to send your account to collections if there is a way to resolve the balance in some other manner. When you contact the billing office we can offer you several options to resolve the balance of your account.

- If you have medical insurance, please contact our office and provide it to the representative so we may file the claim on your behalf.
- Payment Plans are available with the minimum payment of \$10.00 per month, and will keep your account from being sent to collections.
- We also accept Visa, MasterCard and American Express, and will process your payment by mail and over the phone and provide you a confirmation number. Unfortunately, online payments are not currently available, but will be in the future.

Please contact our Billing Office as soon as possible at 512-972-7210



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

CARRIER
PATIENT AND INSURED INFORMATION

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>																													
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1)																													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY					SEX M <input type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)																			
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street)																			
CITY					STATE					8. RESERVED FOR NUCC USE										CITY					STATE														
ZIP CODE					TELEPHONE (Include Area Code) () ()					9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:					11. INSURED'S POLICY GROUP OR FECA NUMBER														
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO										a. INSURED'S DATE OF BIRTH MM DD YY										SEX M <input type="checkbox"/> F <input type="checkbox"/>									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO										b. OTHER CLAIM ID (Designated by NUCC)																			
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO										c. INSURANCE PLAN NAME OR PROGRAM NAME																			
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>																			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____																				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY										15. OTHER DATE MM DD YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. _____										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
17b. NPI _____										19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. _____										22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____										23. PRIOR AUTHORIZATION NUMBER _____																			
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER						E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #																	
1																																							
2																																							
3																																							
4																																							
5																																							
6																																							
25. FEDERAL TAX I.D. NUMBER										SSN EIN <input type="checkbox"/>					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$					29. AMOUNT PAID \$					30. Rsvd for NUCC Use				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & PH # ()																			
SIGNED _____										DATE _____										a. NPI _____					b. _____					a. NPI _____					b. _____				

PHYSICIAN OR SUPPLIER INFORMATION

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1197. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.



Austin/Travis County Health and Human Services Department
 Environmental Health Services Division
 P.O. Box 142529 Austin, Texas 78714
 Phone: 978-0300 Fax: 978-0322



Name of Facility or Home owner _____ Dist # ____ FS Row ID _____

Address: _____ City: _____ Zip Code: _____

Inspected by: _____ Received by: _____ Date: _____

- Y N N/A N/O **1.** Buildings, grounds and equipment are clean, repaired and maintained.
- Y N N/A N/O **2.** Adequate light, ventilation and heat.
- Y N N/A N/O **3.** Sleeping equipment cleaned and linens washed and changed between children and when soiled.
- Y N **4.** Drinking water supplied in a safe and sanitary manner and meeting the standards of the Texas Commission on Environmental Quality(TCEQ). Always available to children.
- UNDETERMINED **A valid document of Water Quality Standards compliance must be submitted to licensing agency for approval.**
- Y N **5.** Sewage system approved, sanitary and meets the standards of TCEQ.
- UNDETERMINED **Valid documentation of On Site Septic System compliance must be submitted to licensing agency for approval.**
- Y N N/A N/O **6.** Garbage and refuse kept and managed as necessary to maintain sanitary conditions inside and outside the facility.
- Y N N/A N/O **7.** Insects and rodents eliminated from premises and extermination performed by professional exterminators.
- Y N N/A N/O **8.** Adequate hand washing facilities supplied with soap and single use towels or individual towels provided and used by children and staff as needed.
- Y N N/A N/O **9.** Single use disposable gloves supplied and used when handling blood or bodily fluids which might contain blood.
- Y N N/A N/O **10.** Diapering done on a clean, washable surface that is disinfected after each use or on a clean, disposable surface that is changed after each use.
- Y N N/A N/O **11.** Soiled diaper containers available and kept clean.
- Y N N/A N/O **12.** Potty-chairs used and sanitized between uses.
- Y N N/A N/O **13.** Toys used by children under 2 are sanitized at least once per day.
- Y N N/A N/O **14.** All food and drinks are safe quality, stored, prepared and served under sanitary and safe conditions.
- Y N N/A N/O **15.** Food equipment is washed and sanitized.
- Y N N/A N/O **16.** Staff with open wounds and/or an injury that inhibits handwashing, such as casts, bandages or braces not allowed to prepare food or change diapers.
- Y N N/A N/O **17.** Single use items not reused.
- Y N N/A N/O **18.** Linens, napkins, bibs and clothes are washed after each use.
- Y N N/A N/O **19.** Cleaning supplies/Toxics are clearly marked, kept separate from food, and kept inaccessible to children.

Additional Comments: _____

Please complete our Environmental Health Services survey at www.surveymonkey.com/s/EHSDSurvey



Austin/Travis County Health and Human Services Department
Environmental Health Services Division
 P.O. Box 142529, Austin, Texas 78714
 (512)978-0300 Fax (512)978-0322



Walk-in Location: 1520 Rutherford LN, NE corner of Rutherford LN @ Cameron RD (No Mail Accepted here)

Farmers Market Food Inspection Report

Vendor Name: _____ Date: _____
 Location: _____ Permit Number: _____
 Farmers Market: _____ Expiration Date: _____
 Permit Type: A-Exempt A B C Start/Stop Time: _____ / _____

Name of Operator: _____ DOB: _____
 Home Address: _____ DL# / State: _____

The items identified below are violations in operations or facilities of this farmers market food service booth. Violations must be corrected immediately and may result in suspension of your permit and/or other legal action.

#	CRITICAL FOOD ITEMS	OUT	IN	NA	NO	COS
1.	Observed operating with a current, valid FARM permit <i>posted</i>					
2.	Food obtained from approved source (No Home Prepared Foods)					
3.	City of Austin Food Manager Certificate Posted					
4.	On-site food preparation properly performed					
5.	Foods cooked and maintained at a proper temperature/Time Control					
Food Temps:						
6.	Handwashing facilities are available and used					
7.	Thermometers available, accurate and used					
8.	Good hygeinic practices (eating/drinking/smoking/other)					
9.	Proper handling of ready to eat foods					
10.	Food, ice, utensils are protected from contamination					
11.	Foods protected/No cross contamination					
12.	No cross-connection of water supply					
13.	Sewage and wastewater disposal system available and adequate					
14.	Food contact surfaces cleaned and sanitized at () ppm					
15.	Ware washing set-up is available and sanitizing at () ppm					
16.	Sanitizer test strips available and used/wiping cloths properly stored					
17.	Floor and overhead coverings are adequate					

Violation Description & Corrective Actions:

_____	CFM: _____
_____	Certificate #: _____
_____	Exp. Date: _____

Charges will be filed in appropriate court upon observation that a food establishment is operating without a current and valid permit.

Received By: _____ Inspected By: _____
 Print Name: _____ Print Name: _____

Please complete our Environmental Health Services survey at www.surveymonkey.com/s/EHSDSurvey

COMPLIANCE ACTIONS

Legal Charges May Be Filed for the Following Violations:

- A) UNAPPROVED FOOD SOURCE. NO HOME PREPARED FOODS MAY BE SERVED TO THE PUBLIC
B) OPERATING WITHOUT A PERMIT OR WITH AN EXPIRED PERMIT
Charges will be filed in appropriate court upon observation that a Farmers Market vendor is operating without a current valid permit *posted*.
- C) OPERATING WITHOUT FOOD MANAGER CERTIFICATION – CLASS C PERMIT ONLY
In the City of Austin and contracted Cities which require a Certified Food Manager, charges will be filed in appropriate court when a Farmers Market vendor is observed operating without a current, valid Austin/Travis County food manager certificate posted.
- D) CRITICAL VIOLATIONS IN FOOD HANDLING
Critical violations in food handling such as improper temperature violations, hygiene violations and wastewater disposal violations will have charges filed in the appropriate court.

IF YOUR PERMIT HAS BEEN SUSPENDED:

You have the right to request a hearing to appeal this ORDER, but the Farmers Market booth must remain closed until this appeal has been decided in your favor or until a sanitarian has confirmed that the imminent health hazard is no longer present. A request for a hearing on your appeal must be made, in writing, within 10 days, to the Health Authority, P.O. Box 142529, Austin, Texas 78714 (Attention: Compliance Coordinator). You may also request a “second opinion” on the findings of this inspection. To do so contact a supervisor in the Environmental Health Division at 512-978-0300.

REASON FOR RE-INSPECTION: An inspection conducted at your business today will require a follow-up inspection to verify and document that necessary corrections have been made. (25 T.A.C. 229.171 (1)(2)(C)). Austin City Ordinance (and contracted cities) requires you to pay a re-inspection fee of \$126. You may pay this fee at the Health Center, located at Rutherford and Cameron Rd. (you **MUST** appear in person), or by phone with a credit card (call 512-978-0300). Please bring a copy of this notice with you when paying in person. A re-inspection will not be scheduled unless the fee has been paid. The fee must be paid before inspection and operation. **YOUR FAILURE TO PAY FOR AND PASS A RE-INSPECTION MAY RESULT IN THE SUSPENSION OF YOUR PERMIT TO OPERATE THIS FARMERS MARKET BOOTH.**

Corrective Actions to Ensure Safe Food

1) Cooling

- Potentially hazardous / TCS food cooled from 135°F to 70°F more than 2 hours OR 135°F to 41°F more than 6 hours OR prepared foods cooled to 41°F more than 4 hours:

Action: Voluntary destruction

2) Cold Hold

- Potentially hazardous / TCS food held above 41°F (45°F) more than 4 hours:

Action: Voluntary destruction

- Potentially hazardous / TCS food held above 41°F (45°F) less than 4 hours:

Action: Rapid cool (e.g. ice bath)

3) Hot Hold

- Potentially hazardous / TCS food held below 135°F more than 4 hours:

Action: Voluntary destruction

- Potentially hazardous / TCS food held below 135°F less than 4 hours:

Action: Rapid reheat to 165°F or more

4) Cooking

- Potentially hazardous / TCS foods undercooked:

Action: Re-cook to proper temperature

5) Rapid Reheating

- Cold potentially hazardous / TCS foods improperly reheated:

Action: Reheat rapidly to 165°F

Office Use Only

Permit # _____ Date Paid _____ Amt \$ _____ Check # _____

Received By _____ Receipt # _____

AUSTIN/TRAVIS COUNTY HEALTH AND HUMAN SERVICES DEPARTMENT

Environmental Health Services Division

P.O. Box 142529 Austin, TX 78714

Phone: (512) 978-0300; Fax: (512) 978-0322

Office Location: 1520 Rutherford Ln, NE corner of Rutherford Ln @ Cameron Rd, East Entrance of Bldg 1 (no mail accepted here)

Food Enterprise Re-Inspection Notice

Date: _____

Permit#: _____

Food Enterprise Name: _____

Address: _____

This is notice that a re-inspection by this Department is required due to one or more of the following deficiencies observed at your Food Enterprise:

Deficiency (check all that apply)	Re-inspection Fee Due By (if applicable)
<input type="checkbox"/> Lack of refrigeration unit(s) to hold foods at proper temperature	
<input type="checkbox"/> Not compliant with Certified Food Manager requirements	
<input type="checkbox"/> Infestation of roaches, rodents, flies, or other vectors	
<input type="checkbox"/> Presence of sewage inside or outside of the establishment	
<input type="checkbox"/> Inadequate or no hot water	
<input type="checkbox"/> Score below 70 on routine inspection or scored re-inspection	
<input type="checkbox"/> Suspension of operating permit due to imminent health hazards	
<input type="checkbox"/> Other: _____	

Do deficiencies require 2 or more re-inspections? Yes No **TOTAL AMOUNT DUE:** _____

A re-inspection must be conducted and approved by this Department within the following timeframe:

Additional Comments: _____

FAILURE TO PAY FOR AND PASS A RE-INSPECTION BY THE COMPLIANCE DATE INDICATED MAY RESULT IN LEGAL ACTION AND/OR THE SUSPENSION OF THE FOOD ENTERPRISE PERMIT.

Sanitarian: _____ **Print Name:** _____

Received by: _____ **Print Name:** _____

- No re-inspection will be scheduled until a re-inspection fee has been paid (when applicable).
- This form must be submitted along with payment to this Department.
- You may submit payment via:
 - walk-in to our office located at 1520 Rutherford Lane (not a mailing address); or,
 - credit card over the phone, but you must first either fax this form to 978-0322 *or* email it to **ECHU.Service@austintexas.gov** and then call 978-0300 to make payment.

FEES <small>(payable to <i>Austin-Travis County Health and Human Services Department (ATCHHSD)</i>)</small>	
City of Austin and Contracted Municipalities	Travis County Jurisdiction
\$126 re-inspection fee for each re-inspection conducted.	No fees
\$126 additional fee for expedited or after-hours re-inspections.	

No refunds for any reason after 180 days from receipt of payment.

Please complete our Environmental Health Services survey at www.surveymonkey.com/s/EHSDSurvey



AUSTIN/TRAVIS COUNTY HEALTH AND HUMAN SERVICES DEPARTMENT

Environmental Health Services Division

P.O. Box 142529

Austin, Texas 78714

Phone: (512) 978-0300 Fax: (512) 978-0322



ESTABLISHMENT: _____ ADDRESS: _____

ROW ID [] [] [] [] [] [] [] [] JURIS [] [] DIST [] [] INSP DATE [] [] [] [] [] []

MONTH DAY YEAR

Time In Time Out

PERMIT EXPIRES [] [] [] [] [] [] [] [] PASS [] FAIL [] schedule follow-up/pay applicable re-inspection fee

INSPECTION PURPOSE:

Certificate of Occupancy [] Change of Ownership (CHOW) [] CHOW-Additional Use []

C.O. Visit # _____ CHOW Follow-up []

Building Permit # _____

Contact Person/Phone # and email address: _____

The items marked "X" below must be completed before approval

- 1. Submit a complete permit application to operate a food establishment.
2. Provide copy of Certificate of Occupancy, contact the building inspection department.
3. Refrigeration to cool at 41° F or below, doors to close properly & have a good seal, thermometers provided.
4. Provide mop sink or curbed drain facility to dispose of wastewater.
5. Provide indirect connection at warewash and culinary sinks, ice maker, ice bins and jockey boxes.
6. Adequate warewashing facilities (ex: dish machine is sanitizing, 3-compartment sink, 2-compartment sink).
7. Hot & cold water supplied to all sinks (100°F minimum for handsinks).
8. Adequate number of handsinks and splash guards.
9. No cross connections (backflow preventers at all threaded hose bibs, spray nozzle above rim).
10. Exterior doors to be tight fitting and have a self-closure.
11. Adequate number of restrooms provided.
12. Self-closures on restroom doors.
13. Restrooms to be provided with forced air mechanical ventilation to the outside.
14. Lights to be shielded or coated in food prep areas, food storage areas, warewashing areas.
15. Walls, floors, ceilings and food prep surfaces to be constructed of smooth, durable, easily cleanable, non-absorbent materials.
16. Must meet City of Austin Smoking Ordinance Requirements.
17. No exposed horizontal conduit or plumbing on walls or ceilings.
18. Dumpster on machine laid asphalt or concrete pad.

NOTE:

- All Food Handlers and Food Managers in the City of Austin are required to be registered with the City of Austin.
Inspection approval does not constitute Permit approval, a Certificate of Occupancy or the building may be occupied/the business may begin operation.

Large empty rectangular box for notes or signatures.

Received By: _____ Inspected By: _____

Printed Name: _____ Printed Name: _____

Please complete our Environmental Health Services survey at www.surveymonkey.com/s/EHSDSurvey



City of Austin

FOOD ESTABLISHMENT INSPECTION REPORT
AUSTIN/TRAVIS COUNTY HEALTH AND HUMAN SERVICES DEPARTMENT
Environmental Health Services Division
P.O. Box 142529
Austin, TX 78714
Phone: (512) 978-0300 Fax: (512) 978-0322



County of Travis

DETENTION ORDER

Establishment Name: _____ Date: _____

Address: _____ Permit: _____

This is to inform you that a condition in violation of State Law, City Ordinance or Travis County Regulation exists at this food establishment. In accordance with Chapter 431.048 of the Texas Health and Safety Code, Section 10-3-157 of the Code of the City of Austin, or Chapter 47 of the Travis County Policies, Procedures and Regulations Manual, the food or equipment identified to you by the Sanitarian serving this order is hereby detained.

[] Food Items identified below has been produced, prepared or held under conditions whereby it may have been contaminated and is therefore considered to be an imminent health hazard. These food are hereby detained and may not be used, served, sold or moved from this establishment without the permission of the sanitarian serving this order.

Four horizontal lines for listing food items.

[] Equipment identified below is unable to hold potentially hazardous foods at proper temperatures and is considered to be an imminent health hazard. This equipment is detained and may not be used without the permission of the sanitarian serving this order.

Two horizontal lines for listing equipment.

[] Other _____

You are entitled to a hearing on this order to determine the disposition of this food or equipment. A written request for such a hearing must be made within ten days of today's date and addressed to Austin/Travis County Health Authority, Attn: Compliance Coordinator, P.O. Box 142529 Austin, TX 78714. If such request has not been received within the time specified this food shall be destroyed under the supervision of the Sanitarian issuing this order. Failure to comply with this notice may subject you to administrative, criminal and/or civil penalties.

Respectfully,

Inspector serving this notice may be contacted at 978-0300 from 7:45 AM - 4:45 PM, Mon.-Fri.

Sanitarian/Phone # _____ Print _____ Received By _____ Print _____

Sanitarian _____ Signature _____ Received By _____ Signature _____



City of Austin

AUSTIN/TRAVIS COUNTY HEALTH AND HUMAN SERVICES DEPARTMENT
ENVIRONMENTAL HEALTH SERVICES DIVISION
P.O. Box 142529
Austin, TX 78714
Tel: (512) 978-0300; FAX: (512)978-0322



County of Travis

**ENVIRONMENTAL HEALTH SERVICES DIVISION
FIELD INSPECTION REPORT**

Date: _____ Time: _____

Establishment Name: _____

Address: _____

Report Directed to: _____

Received by

Sanitarian

Please complete our Environmental Health Services survey at www.surveymonkey.com/s/EHSDSurvey

Revised 9-8-14

Corrective Actions to Ensure Safe Food

Item No.

1 Cooling

- Potentially hazardous / TCS food cooled from 135°F to 70°F more than 2 hours **OR** 135°F to 41°F more than 6 hours **OR** prepared foods cooled to 41°F more than 4 hours:

Action: Voluntary destruction

2 Cold Hold

- Potentially hazardous / TCS food held above 41°F (45°F) more than 4 hours:

Action: Voluntary destruction

- Potentially hazardous / TCS food held above 41°F (45°F) less than 4 hours:

Action: Rapid cool (e.g. ice bath)

3 Hot Hold

- Potentially hazardous / TCS food held below 135°F more than 4 hours:

Action: Voluntary destruction

- Potentially hazardous / TCS food held below 135°F less than 4 hours:

Action: Rapid reheat to 165°F or more

4 Cooking

- Potentially hazardous / TCS foods undercooked:

Action: Re-cook to proper temperature

5 Rapid Reheating

- Cold potentially hazardous / TCS foods improperly reheated:

Action: Reheat rapidly to 165°F

7 Handwashing

- Food employees observed not washing hands:

Action: Employees should be instructed to wash hands as specified in the Rules.

9 & 10 Approved Source/Sound Condition

- Foods from unapproved sources/unsound condition:

Action: Detention or voluntary destruction

11 Proper Handling of Ready-to-Eat Foods

- Ready-to-Eat foods handled with bare hands and employee did not properly wash hands before handling:

Action: Voluntary destruction

12 Cross Contamination of Raw/Cooked Foods

- Ready-To-Eat foods contaminated by raw potentially hazardous / TCS foods:

Action: Voluntary destruction of ready-to-eat foods

13 Approved Systems

- HACCP Plans for ROP, shellfish tanks, variances, others
- Written procedure for time as a public health control

14 Water Supply

- Facility does not have water for washing hands, preparing foods, or cleaning equipment and utensils:

Action: Voluntary suspension of food service operations and preparation

COMPLIANCE ACTIONS

1. Food Enterprise Permits:

Charges will be filed in appropriate court upon observation that a food establishment is operating without a current valid permit.

10-3-62 (A) A permit holder or person in charge of a Food Enterprise shall post a permit required by this chapter in a prominent public location clearly visible to the general public and to patrons. A permit is clearly visible to the general public and to patrons if:

- (1) it is posted in the front window of the enterprise within 5 feet of the front door; or
- (2) it is posted in a display case mounted on the outside front wall of the enterprise within 5 feet of the front door; or
- (3) it is posted on the drive-through menu board of a drive-through enterprise, in addition to posting in locations (1) & (2) of this section; or
- (4) the Food Enterprise is operated in a space that prevents posting the permit as required in (A)(1) through (3), the permit shall be posted in the initial patron contact area, on the menu board or counter of the enterprise, or in a location determined by the health authority to ensure proper notice to the general public and patrons.

2. Certified Food Manager required to be Registered with the City of Austin. Prominently Post Certificate.

If located in the City of Austin, charges may be filed when a Food Enterprise fails to post in a prominent location an original Food Manager Certificate issued by the Austin/Travis County Health Authority.

3. Food Handler Registration - City of Austin Only

All Food Enterprise Employees are required to complete Food Handler training and be registered with the City of Austin. At the time of annual permit renewal a person operating a Food Enterprise is required to provide a list of all Food Handlers at the enterprise along with their City of Austin Food Handler Registration Numbers to the Health Department. Food Handler info will be sent with your permit renewal. Charges filed for failure to comply.

4. Scores below 70:

A scored follow-up inspection will be conducted after 10 days from today. Failure to score 70 or above on this re-inspection will result in a criminal complaint being filed in the appropriate Municipal or Justice of the Peace Court for violations of the Texas Food Establishment Rules. Failure to score 70 or above on subsequent scored inspections within a thirty-six (36) month period may result in additional charges being filed, suspension or revocation of your Food Enterprise Permit and closure of this establishment. You would have the opportunity to appeal any such revocation to the Health Authority for Austin and Travis County.

See the Compliance Schedule below:

1st score below 70

- Re-inspection fee and re-inspection after 10 days.

2nd score below 70 within 36 months of first failing score

- Re-inspection fee and re-inspection after 10 days.
- File criminal complaint in appropriate court.

3rd score below 70 within 36 months of first failing score

- Re-inspection fee and re-inspect after 48 hours.
- File criminal complaint in appropriate court.
- Permit suspended, immediate closure for 48 hours.

4th score below 70 within 36 months of first failing score

- Permit suspended, immediate indefinite closure.
- Permit revocation process is started.

- Any Food Enterprise that scores below 70 or has the permit suspended will be required to have all of their Food Handlers obtain training and become registered within 30 days of the inspection.

NOTE: A SCORE BELOW 50 ON ANY SCORED INSPECTION WILL RESULT IN AN IMMEDIATE 48 HOUR CLOSURE, RE-INSPECTION AFTER 48 HOURS AND A COMPLAINT FILED IN COURT.



City of Austin

AUSTIN/TRAVIS COUNTY HEALTH AND HUMAN SERVICES DEPARTMENT
ENVIRONMENTAL HEALTH SERVICES DIVISION

P.O. Box 142529

Austin, TX 78714

Phone 978-0300

FAX 978-0322



Travis County

ORDER SUSPENDING FOOD ESTABLISHMENT PERMIT

Food Establishment: _____

Address: _____ **Date:** _____

Person in charge or permit holder: _____

THIS IS TO INFORM YOU THAT YOUR FOOD ESTABLISHMENT HAS BEEN FOUND TO BE IN VIOLATION OF THE "TEXAS FOOD ESTABLISHMENT RULES" AND CHAPTER 10-3 OF THE CODE OF THE CITY OF AUSTIN OR CHAPTER 47 OF THE TRAVIS COUNTY POLICIES, PROCEDURES AND REGULATIONS MANUAL AND, IN ACCORDANCE WITH SECTION 229.171 OF THESE FOOD ESTABLISHMENT RULES AND CHAPTER 431 OF THE TEXAS HEALTH AND SAFETY CODE, YOUR PERMIT TO OPERATE THIS ESTABLISHMENT IS HEREBY SUSPENDED. YOU ARE REQUESTED TO CLOSE THIS ESTABLISHMENT IMMEDIATELY. FAILURE TO DO SO WILL MAKE YOU SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

Your permit has been suspended due to one or more of the following conditions:

The presence of an imminent health hazard; to wit: _____

Score below 50. Date of inspection: _____

3rd Score below 70 in 36 months

4th Score below 70 in 36 months

Score below 70. No re-inspection due to failure to pay re-inspection fee.

Critical violation from inspection on __/__/__. No re-inspection due to failure to pay re-inspection fee.

You have the right to request a hearing to appeal this **ORDER**, but the food establishment must remain closed until this appeal has been decided in your favor or until a sanitarian has confirmed that the imminent health hazard no longer exists or until _____ at _____M. A request for a hearing on your appeal must be made in writing within 10 days to the Health Authority @ P. O. Box 142529 Austin, Texas 78714 (Attention: Compliance Coordinator). You may also request a "second opinion" on the findings of this inspection. To request a second opinion, contact:

_____, Supervisor, Environmental Health Services Division, at 512-978-0300.

The Inspector serving this notice may be contacted at 512-978-0300 between 7:45 AM - 4:45 PM, Monday thru Friday.

Sanitarian _____ **Received By** _____
Print **Print**

Sanitarian _____ **Received By** _____
Signature **Signature**



City of Austin

AUSTIN/TRAVIS COUNTY HEALTH AND HUMAN SERVICES DEPARTMENT
ENVIRONMENTAL HEALTH SERVICES DIVISION

P.O. Box 142529
Austin, TX 78714

Phone 978-0300 FAX 978-0322



Travis County

NOTICE OF COMPLIANCE SCHEDULE

Food Establishment: _____

Address: _____ Date: _____

Person in Charge/Permit Holder: _____

Date of Inspection: _____ Score: _____

This is to notify you that on this date a scored inspection was conducted at this food establishment and numerous critical violations of the "Texas Food Establishment Rules" were found, resulting in an inspection score below 70. Accordingly, this establishment is now subject to the compliance review process summarized below. You have the right to request a second opinion regarding this inspection. To make such a request, call:

_____, Supervisor, Environmental Health Services Division at 978-0300.

RE-INSPECTIONS

A scored follow-up inspection will be conducted to verify correction of critical violations. A re-inspection fee is required for each compliance follow-up visit. Failure to score 70 or above on this or subsequent re-inspections will result in additional compliance actions including additional re-inspection fees, a criminal complaint being filed in the appropriate Municipal or Justice of the Peace Court, and/or suspension or revocation of your Food Establishment Permit resulting in closure of this establishment. You have the opportunity to appeal any such revocation to the Health Authority for Austin and Travis County. See the Compliance Schedule below:

1st score below 70

- Re-inspection fee and re-inspection after 10 days.

2nd score below 70 within 36 months of first failing score

- Re-inspection fee and re-inspection after 10 days.
- File criminal complaint in appropriate court.

3rd score below 70 within 36 months of first failing score

- Re-inspection fee and re-inspect after 48 hours.
- File criminal complaint in appropriate court.
- Permit suspended, immediate closure for 48 hours.

4th score below 70 within 36 months of first failing score

- Permit suspended, immediate indefinite closure.
- Permit revocation process is started.

Any score below 50

- Re-inspection fee and re-inspect after 48 hours.
- File criminal complaint in appropriate court.
- Permit suspended, immediate closure for 48 hours

NOTE: Any Food Enterprise that scores below 70 or has the permit suspended will be required to verify that all of their Food Handlers have obtain training and are registered with the City of Austin as required, within 30 days of the inspection.

Sanitarian/Phone # _____ Print _____ Received By _____ Print _____

Sanitarian _____ Signature _____ Received By _____ Signature _____

COMPLIANCE ACTIONS

1. Permits:

Charges will be filed in the appropriate court upon observation that a Food Enterprise is operating without a current valid permit. All Food Enterprises in Austin and Travis County are required to be permitted by this Department.

The definition of a Food Enterprise includes Food Processing Plants. Food Processing Plants are defined by state law as a commercial operation that manufactures, packages, labels, or stores food for human consumption and does not provide food directly to a consumer.

2. Certified Food Manager:

If located in the City of Austin, charges may be filed when a Food Enterprise fails to post in a prominent location an original Food Manager Certificate issued by the Austin/Travis County Health Authority. A certified food manager is required for all wholesale food products, food processing, food warehousing establishments with the following exception:

A food manager certificate is not required for a Food Processing Plant that is inspected at least once each week by a state or federal food sanitation inspector or that only stores prepackaged food that is not potentially hazardous.

3. Re-Inspections:

If deficiencies requiring a re-inspection to verify corrections have been made were observed by staff with this Department at your Food Enterprise, and your establishment is located in the City of Austin, Austin City Ordinance requires you to pay a re-inspection fee.

FAILURE TO PAY FOR A RE-INSPECTION MAY RESULT IN LEGAL ACTION OR THE SUSPENSION OF YOUR PERMIT TO OPERATE THIS FOOD ENTERPRISE.

References:

- Texas Administrative Code, Title 25, Chapter 229, Subchapter N – Good Manufacturing/Warehousing Practices
- Texas Administrative Code, Title 25, Chapter 229, Subchapter K – Texas Food Establishment Rules
- City of Austin Code of Ordinances, Ch. 10-3, Food and Food Handlers



AUSTIN/TRAVIS COUNTY HEALTH AND HUMAN SERVICES DEPARTMENT

Environmental Health Services Division

P.O. Box 142529 Austin, Texas 78714

Phone: (512) 978-0300 Fax: (512) 978-0322



MOBILE FOOD VENDOR INSPECTION REPORT

Name of Business: _____ Date: _____

Permit Holder: _____ Decal #: _____ Expiration: _____

Address of Inspection: _____ Start/Stop Time: _____ / _____

Type of Unit: Motor Vehicle Pushcart Other (Specify) _____ # of Staff: _____

If a Motor Vehicle: Make: _____ Year: _____ Model: _____

Lic #: _____ State: _____

Type of Food Sold: _____ Unrestricted (open food) _____ Restricted (prepackaged food)

Name of operator: _____ DOB _____

DL # of operator: _____ State: _____

Address: _____ Street Apt City State Zip

The items identified below are violations in operations or facilities of this mobile food unit. VIOLATIONS MUST BE CORRECTED IMMEDIATELY AND MAY RESULT IN SUSPENSION OF YOUR PERMIT AND/OR OTHER LEGAL ACTION.

Table with 7 columns: CRITICAL FOOD ITEMS, OUT, IN, N/A, NO, COS. Rows include items like 'Observed operating with a current, valid mobile food vending permit', 'Cold hold', 'Hot hold', 'Cooling', 'Cooking temperatures', 'Hygienic practices', 'Thermometers present', 'UNRESTRICTED UNITS', 'Hot and cold water supply adequate', 'Wastewater holding tank adequate/Improper Wastewater Disposal', 'Soap and towels at handsink', 'Utensils/Warewashing/Food Contact Surfaces', 'Food Manager Certificate conspicuously posted', 'Unit Altered and/or Modified From Permitting Inspection', 'Unit Permanently Connected to Utility', 'Other:'. Row 8 and row 9 are shaded.

Permit to Operate SUSPENDED Follow-up inspection needed – FEE REQUIRED Yes No

Comments/other items: _____

Received By: _____

Printed Name: _____

Inspected By: _____

CFM: _____
Certificate #: _____
Exp. Date: _____

Please complete our Environmental Health Services survey at www.surveymonkey.com/s/EHSDSurvey

Permits are not transferable to another person or another unit.

- Unrestricted Units cannot operate without running hot and cold water and proper holding tank for wastewater.
- Units may not be permanently connected to any utilities at any time.
- Units must report to the approved, on-record, central preparation facility for resupplying the unit, for water restocking, and water disposal.

Legal Charges May Be Filed for the Following Violations

A) **UNAPPROVED FOOD SOURCE. NO HOME PREPARED FOODS MAY BE SERVED TO THE PUBLIC**

B) **OPERATING WITHOUT A PERMIT OR WITH AN EXPIRED PERMIT**

Charges will be filed in appropriate court upon observation that a mobile unit is operating without a current valid permit.

C) **OPERATING WITHOUT FOOD MANAGER CERTIFICATION**

In the City of Austin and contracted Cities which require a Certified Food Manager, charges will be filed in appropriate court when a Mobile Food Establishment is observed operating without a valid Austin/Travis County food manager certificate posted on the unit.

D) **CRITICAL VIOLATIONS IN FOOD HANDLING**

Critical violations in food handling such as improper temperature violations, hygiene violations and wastewater disposal violations will have charges filed in the appropriate court.

E) **PERMIT SUSPENSION DUE TO ONE OR MORE OF THE FOLLOWING CONDITIONS**

Item #'s 2, 8a, 8b, 10 and/or 11

THIS IS TO INFORM YOU THAT YOUR FOOD ESTABLISHMENT HAS BEEN FOUND TO BE IN VIOLATION OF THE "TEXAS FOOD ESTABLISHMENT RULES" AND CHAPTER 10-3 OF THE CODE OF THE CITY OF AUSTIN/OR CHAPTER 47 OF THE TRAVIS COUNTY POLICIES, PROCEDURES AND REGULATIONS MANUAL AND, IN ACCORDANCE WITH SECTION 229.171 OF THESE FOOD ESTABLISHMENT RULES AND CHAPTER 431 OF THE TEXAS HEALTH AND SAFETY CODE, YOUR PERMIT TO OPERATE THIS ESTABLISHMENT IS HEREBY SUSPENDED. YOU ARE REQUESTED TO CLOSE THIS ESTABLISHMENT IMMEDIATELY. FAILURE TO DO SO WILL MAKE YOU SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

IF YOUR PERMIT HAS BEEN SUSPENDED DUE TO ONE OR MORE OF THE FOLLOWING CONDITIONS: Item #'s 2, 8a, 8b, 10 and/or 11.

You have the right to request a hearing to appeal this ORDER, but the food establishment must remain closed until this appeal has been decided in your favor or until a sanitarian has confirmed that the imminent health hazard no longer. A request for a hearing on your appeal must be made, in writing, within 10 days, to the Health Authority, P.O. Box 142529, Austin, Texas 78714 (Attention: Compliance Coordinator). You may also request a "second opinion" on the findings of this inspection. To do so, contact a supervisor in the Environmental Health Division at 512-978-0300.

REASON FOR RE-INSPECTION: An inspection conducted at your food establishment today will require a follow-up inspection to verify and document that necessary corrections have been made. (25 T.A.C. 229.171 (1)(2)(C)). Austin City Ordinance requires you to pay a re-inspection fee of \$125. You may pay this fee at the Health Center, located at Rutherford and Cameron Rd. (you **MUST** appear in person), or by phone with a credit card (call 512-978-0300). Please bring a copy of this notice with you when paying in person. A re-inspection will not be scheduled unless the fee has been paid. The fee must be paid before inspection and operation. **YOUR FAILURE TO PAY FOR AND PASS A RE-INSPECTION MAY RESULT IN THE SUSPENSION OF YOUR PERMIT TO OPERATE THIS FOOD ESTABLISHMENT. Note: You must bring your own power source for your mobile unit if the reason for the re-inspection is related to refrigeration and/or water usage.**

REMINDERS for City of Austin Vendors: Submit your quarterly itinerary report every three months (or as requested) to the Environmental Health Services Division. Maintain your monthly Central Preparation Facility log for renewal.



Customer # _____

AUSTIN/TRAVIS COUNTY HEALTH AND HUMAN SERVICES DEPARTMENT
Environmental Health Services Division
P.O. Box 142529
Austin, Texas 78714
Phone: (512) 978-0300 Fax: (512) 978-0322



MOBILE FOOD VENDOR PERMIT INSPECTION REPORT

Name: _____ **Date:** _____

Permit Holder: _____ **RSN #** _____

Type of Unit: Motor Vehicle ___ Trailer ___ Pushcart ___ Other (Specify) _____

If a Motor Vehicle: Make _____ Year _____

Model _____ Lic # _____ State _____

INSPECTION TYPE: New Permit Permit Renewal Re-inspection

PERMIT TYPE: Unrestricted (open food) Restricted (pre-packaged food)

Area of Operation
 _____ City of Austin Jurisdiction **ONLY**
 _____ Travis County Jurisdiction **ONLY**
 Write "X" in applicable blank

CRITICAL OPERATIONAL REQUIREMENTS

The below requirements are conditions of the Mobile Food Vendor Permit. Failure to comply with any of the below requirements may result in permit suspension, a re-inspection and/or legal action.

UNRESTRICTED units operating in the **City of Austin/other municipalities** – see **Critical Requirements 1 thru 9.**

UNRESTRICTED units operating in **Travis County/unincorporated areas** – see **Critical Requirements 3 thru 9.**

RESTRICTED units (**both CITY & COUNTY**) – see **Critical Requirements 4 thru 10.**

1. An original and current CITY OF AUSTIN issued Food Manager’s Certificate must be obtained and POSTED on the unit AT ALL TIMES.
2. Each employee must maintain a valid CITY OF AUSTIN issued Food Handler Registration AT ALL TIMES.
3. Hot water shall be available for immediate use at all required sinks AT ALL TIMES.
4. Cold and hot-held potentially hazardous foods shall be held at required temperatures AT ALL TIMES.
5. Waste fluids/materials shall be secured to prevent potential contamination of ground or unit surfaces.
6. All operational equipment/materials, such as propane tanks, generators, etc, must be maintained on unit AT ALL TIMES.
7. NO hard-plumbing or wiring to water, power sources, or other utilities are allowed AT ANY TIME.
8. NO modifications to the unit after permit issuance may be made without authorization/inspection by this Department.
9. The unit must be operated/maintained in a sanitary manner as per Texas Food Establishment Rules AT ALL TIMES.
10. ONLY pre-packaged food products may be sold or offered under a Restricted Permit.

Austin Fire Department (AFD) approval required: YES NO **AFD approval granted: YES NO**
 Fresh water _____ / Waste Water _____

INSPECTION
PASS FAIL
 Permit # _____
 Expiration Date: _____

Received By: _____ Inspected By: _____

Print Name: _____ Print Name: _____

By signing this document I confirm that I have read and understood the mobile food vendor responsibilities listed on both sides of this document and affirm that I will comply with those responsibilities.

Please complete our Environmental Health Services survey at www.surveymonkey.com/s/EHSDSurvey

MOBILE FOOD VENDOR RESPONSIBILITIES

1. **OPERATION:** All state and local rules and ordinances related to the mobile vending operation must be adhered to at all times.
2. **NO HOME PREPARED FOOD MAY BE SERVED TO THE PUBLIC.**
3. **THE USE OF EXTERNAL EQUIPMENT IS NOT ALLOWED.** All equipment **MUST** be contained within or on the mobile unit at all times and must be properly enclosed.
4. **CENTRAL PREPARATION FACILITY (CPF) USE:** Report to your central preparation facility to service your unit. No open food preparation or handling may occur at the CPF unless the mobile vending permit owner holds a separate and valid Food Establishment permit at the CPF location. A CPF Log sheet documenting all CPF visits must be maintained on the mobile vending unit at all times for review at the request of the Health Department.
5. **REFRIGERATION AND HEATING:** Unit must have adequate hot and cold food storage facilities to maintain food products at the required temperatures. Hot foods must be held at 135°F or above. Cold foods must be stored at 41°F or below.
6. **THERMOMETER:** Metal stem dial thermometers with a range of 0-220°F and accurate to +/- 2°F must be provided on mobile food units on which food is prepared in order to monitor food temperatures. Locate additional thermometers in all refrigeration/cold-hold units.
7. **LABELING:** All pre-packaged, self-service food items offered must be properly labeled in adherence with the Texas Food Establishment Rules requirements.
8. **MOBILITY:** Units must maintain a state of mobile readiness at all times. The health authority prohibits alteration, removal, attachments, placement or change in, under, or upon the mobile food establishment that would prevent or otherwise reduce ready mobility.
9. **UTILITIES/WATER:** Permanent utilities (i.e. plumbing, gas, electrical, water) may not be attached to the unit at any time. At no time during operation is the mobile unit to be attached to a water hose or any other permanent water supply.
10. **HOLDING TANKS:** Fresh and wastewater holding tanks must be properly sized, permanently installed on the unit and equipped with a valve to empty/fill the tanks from the exterior of the unit in a manner which prevents contamination of ground surfaces or mobile unit.
10. **HOT AND COLD WATER:** Unrestricted units must maintain a safe and secure water supply. Hot water must be available for immediate use to all sink basins at all times of operation.
11. **HANDWASHING:** Soap, single use towels and hot water must be supplied to hand sinks at all times.
12. **CERTIFIED FOOD MANAGER / FOOD HANDLER:** Unrestricted units must post and maintain at least one (1) employee's original and valid City of Austin Food Manager Certificate on unit at all times. All other employees must be registered as Food Handlers with the City of Austin Health Department. A verification list of all employees Food Manager and Food Handler credentials must be submitted at time of permit renewal. Failure to comply may result in additional compliance fees being assessed.
13. **ZONING:** In the city limits of Austin, contact City of Austin Zoning and Right-of-Way Departments to determine if vending site is approved.



Austin/Travis County Health and Human Services Department
Environmental Health Services Division
 P.O. Box 142529, Austin, Texas 78714
 (512)978-0300 Fax (512)978-0322



Walk-in Location: 1520 Rutherford LN, NE corner of Rutherford LN @ Cameron RD (No Mail Accepted here)

Temporary Food Inspection Report

Name of Event: _____
 Address: _____
 Booth: _____
 Type of Food: _____

Date: _____
 Permit Number: _____
 Inspection Start Time: _____
 Inspection Stop Time: _____

Name of Operator: _____ DOB: _____
 Home Address: _____ DL# / State: _____

The items identified below are violations in operations or facilities of this temporary food service booth. Violations must be corrected immediately and may result in suspension of your permit and/or other legal action.

#	CRITICAL FOOD ITEMS	OUT	IN	NA	NO	COS
1.	Observed operating with a current, valid temporary food permit					
2.	Food obtained from approved source (No Home Prepared Foods)					
3.	Handwashing facilities are available and used					
4.	Foods cooked and maintained a proper temperature					
<i>Food Temps:</i>						
5.	Thermometers available and accurate					
6.	Good hygeinic practices (eating/drinking/smoking/other)					
7.	Proper handling of ready to eat foods					
8.	Food, ice, utensils are protected from contamination					
9.	No cross contamination					
10.	No cross-connection of water supply					
11.	Sewage and wastewater disposal system available and adequate					
12.	Food contact surfaces cleaned and sanitized at () ppm					
13.	Ware washing set-up is available and sanitizing at () ppm					
14.	Sanitizer test strips available					
15.	Floor and overhead coverings are adequate					

Violation Description & Corrective Actions:

Charges will be filed in appropriate court upon observation that a food establishment is operating without a current and valid permit.

Received By: _____ Inspected By: _____
 Printed Name: _____ Printed Name: _____

Please complete our Environmental Health Services survey at www.surveymonkey.com/s/EHSDSurvey

Corrective Actions to Ensure Safe Food

The Following Violations May Result in Permit Suspension and/or Legal Charges:

Permit

- No current valid Permit issued and posted.

Corrective action: Immediate closure

Approved Source/Sound Condition - NO HOME PREPARED FOOD ALLOWED

- Foods from unapproved sources/unsound condition.

Corrective action: Detention of voluntary destruction.

Handwashing

- Employee(s) not washing hands.

Corrective action: Employees should be instructed to wash hands before starting work and after smoking, eating, drinking, using the toilet, and all other times specified in the Rules.

Cold Hold

- Potentially Hazardous Food held above 41 °F (45 °F) more than 4 hours.

Corrective action: Voluntary destruction.

- Potentially Hazardous Food held above 41 °F (45 °F) less than 4 hours.

Corrective action: Rapid cool (e.g. ice bath).

Hot Hold

- Potentially hazardous food held below 135 °F more than 4 hours.

Corrective action: Voluntary destruction.

- Potentially Hazardous Food held below 135 °F less than 4 hours.

Corrective action: Rapid re-heat to 165 °F or more.

Cooking

- Potentially Hazardous Foods undercooked.

Corrective action: Re-cook to proper temperature / voluntary destruction.

Rapid Re-heating

- Cold Potentially Hazardous Foods improperly re-heated.

Corrective action: Re-heat rapidly to 165 °F.

Handling of Ready-to-Eat Foods

- Employee(s) handling Ready-to-Eat Foods with bare hands without proper handwashing.

Corrective action: Voluntary destruction.

Cross Contamination of Raw/Cooked Foods

- Ready-To-Eat Foods contaminated by raw Potentially Hazardous Foods.

Corrective action: Voluntary destruction of Ready-To-Eat Foods.

Texas Department of State Health Services, [Texas Food Establishment Rules 229.161 -- 229.171](#) states: "...The regulatory authority may impose additional requirements to protect against health hazards related to the conduct of the temporary food service establishment, may prohibit the sale of some or all Potentially Hazardous Foods, and when no health hazard will result, may waive or modify requirements of these rules. [Austin City Code 10-3-154](#) requires immediate corrective action for all items or establishment must cease operations until items are corrected and approval to reopen is given by the Health Department.



AUSTIN/TRAVIS COUNTY HEALTH AND HUMAN SERVICES DEPARTMENT

ENVIRONMENTAL HEALTH SERVICES DIVISION
P.O. Box 142529 Austin, Texas 78714
Phone (512) 978-0300 Fax (512) 978-0322



Name: _____ Date: _____

Mailing Address: _____

Violation Address: _____

This is to inform you that a condition in violation of State Law and/or County Regulation exists on this property.

Legal Description: _____,

Lot: _____ Block: _____ Subdivision: _____ Section: _____

Jurisdiction: _____ in Travis County, Texas.

In accordance with Chapter 61 of the Travis County Policies, Procedures, and Regulations Manual and Chapter 341, 343 and 365.011 of the Texas Health and Safety Code, you must abate a condition constituting a public nuisance, to wit:

- High grass and weeds _____
- Litter/Rubbish, trash and debris _____
- Objectionable material _____
- Standing water _____
- Sewage and wastewater exposed in such a way as to be a potential instrument or medium in the transmission of disease _____
- Abandoned/Junk Vehicles _____
- Substandard Structure _____

Under this Chapter, the term “abate”, means to “eliminate by removal, repair, rehabilitation, or demolition.”

THIS CONDITION MUST BE CORRECTED WITHIN _____ DAYS/HOURS AFTER THE DATE ON WHICH THIS NOTICE IS RECEIVED. FAILURE TO COMPLY WITH THIS NOTICE WITHIN THE TIME SPECIFIED MAY RESULT IN LEGAL ACTION.

Failure to abate the public nuisance condition above, within the time period indicated, may also subject you to formal abatement proceedings, which could result in liability for the cost of abating the conditions on this property by the County, and additional administrative fees. Any costs of such abatement will, under the provisions of Chapter 61 of the Travis County Policies, Procedures, and Regulations Manual and Chapter 343 of the Texas Health and Safety Code, constitute a lien upon the property upon which such abatement was done.

Respectfully,

Investigator serving this notice may be contacted by calling
(512)978-0300 - **PLEASE CALL**

Printed Name (Registered Sanitarian)

RECEIVED BY: _____ **PRINT:** _____

**AUSTIN/TRAVIS COUNTY HEALTH AND HUMAN SERVICES DEPARTMENT
ENVIRONMENTAL HEALTH SERVICES DIVISION**

P.O. Box 142529
Austin, TX 78714

Phone: (512) 978-0300; Fax: (512) 978-0322



City of Austin



County of Travis

NOTICE OF VIOLATION

Date: _____

Name of Owner/Tenant: _____

Address: _____ Texas _____

This is to inform you that a condition in violation of County Regulations/City Ordinance and/or

State Law exists on your property at _____, Travis County.

In accordance with **Austin City Code 3-2-11(A)(3)** Animal enclosures must be maintained in a sanitary condition that does not allow flies to breed or cause an odor offensive to an adjacent residence or business, and in accordance with **Austin City Code 3-2-13** an enclosure used to keep six or more dogs, other than puppies less than four months old, must be located at least 50 feet from an adjacent residence or business, excluding the residence or business of the owner or handler of the dogs.

Notice has been issued for the following reasons:

- () Observed [] dogs roaming the property
- () Observed enclosure in an unsanitary condition

Corrective Actions:

Received by: _____

Must be corrected within _____

FAILURE TO COMPLY WITH THIS NOTICE WITHIN THE TIME SPECIFIED MAY RESULT IN LEGAL ACTION.
(Possible fine of up to \$ 2000.00 per violation per day)

Inspector serving this notice may be contacted at 512-978-0300

Respectfully,
Austin/Travis County Health and Human
Services Department

Issued By: _____
City of Austin Sanitarian

**AUSTIN/TRAVIS COUNTY HEALTH AND HUMAN SERVICES DEPARTMENT
ENVIRONMENTAL HEALTH SERVICES DIVISION**

P.O. Box 142529

Austin, TX 78714

Phone: (512) 978-0300; Fax: (512) 978-0322



City of Austin



County of Travis

NOTICE OF VIOLATION

Date: _____

Name of Owner/Occupant: _____

Address: _____, Texas _____

This is to inform you that a condition in violation of Austin City Code, Title 3 - Animal Regulation, exists on your property at

Observed Violation(s): *(check all that apply)*

- In accordance with Austin City Code 3-2-1, an owner or handler may not allow fowl to run at large (outside an enclosure).
- In accordance with Austin City Code 3-2-11(A)(3), animal enclosures must be securely built, adequately sized for the kind and number of animals and maintained in a sanitary condition that does not allow flies to breed or cause an odor offensive to an adjacent residence or business.
- In accordance with Austin City Code 3-2-16, an enclosure used to keep two or more fowl must be located at least 50' feet from a residence or business, excluding the residence or business of the fowl's owner or handler.

Condition(s): _____

Corrective Action(s): _____

RECEIVED BY: _____

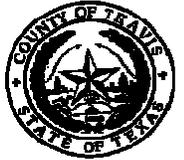
THE ABOVE-REFERENCED VIOLATION(S) MUST BE CORRECTED WITHIN _____ DAYS.

FAILURE TO COMPLY WITH THIS NOTICE WITHIN THE TIME SPECIFIED MAY RESULT IN LEGAL ACTION.
(Possible fine of up to \$ 2000.00 per violation per day)

Inspector serving this notice may be contacted at 512-978-0300

Respectfully,
Austin/Travis County Health and Human Services Department

Notice of Violation Issued By: _____
Sanitarian



SWIMMING POOL & SPA C.O./CHOW INSPECTION REPORT

ESTABLISHMENT: _____ ADDRESS: _____

ROW ID

--	--	--	--	--	--	--	--	--	--

 JURIS

--	--

 DIST

--	--

 INSP DATE

MONTH	DAY	YEAR	

 TIME IN

--	--

 TIME OUT

--	--

Type of Inspection: Certificate of Occupancy Change of Ownership (CHOW) Inspection Result: PASS FAIL Re-Inspection required prior to next CHOW Inspection?

Building Permit #: _____ Initial Construction Date of Pool/Spa (*circle one*): **PRE-10/1/99** **POST-10/1/99**

Contact Person Name, Phone # and/or email address: _____

The items marked "X" below must be completed before approval

1. ___ Enclosures (including gates, doors & windows), non-climbable structures
2. ___ Entries/exits
3. ___ Decking & coping
4. ___ Steps, seat benches, water lounges, vanishing edge, misc.
5. ___ Deep/shallow water transitional lines, ropes & floats
6. ___ Depth markings
7. ___ "NO DIVING" w/international symbol
8. ___ Suction outlets
9. ___ Return inlets
10. ___ Skimmers
11. ___ Signage
12. ___ Life-saving equipment
13. ___ Emergency phone/summoning device
14. ___ Circulation equipment & appurtenances; i.e., gauges, SVRS, piping, flow direction arrows, filtration, pump, etc
15. ___ Lighting
16. ___ Disinfection & pH levels
17. ___ Emergency shut-off switch
18. ___ Spa timer switch
19. ___ Storage of chemicals
20. ___ Bathhouse & sanitary facilities
21. ___ Diving facilities

Comments: _____

Received By: _____ Inspected By: _____

Printed Name: _____ Printed Name: _____

Please complete our Environmental Health Services survey at www.surveymonkey.com/s/EHSDSurvey

NOTE: ALL OWNERS/OPERATORS ARE RESPONSIBLE FOR KNOWLEDGE OF ALL SWIMMING POOL/SPA RULES

MAIN DRAIN/SUCTION OUTLET AND SVRS REQUIREMENTS

Pools and spas built prior to 10/1/99 that are 4 feet deep or less (as measured from the normal water level to the suction outlets/main drains) must have for each suction system: two or more hydraulically balanced suction outlets with approved covers (defined below) or approved grates (defined below) with a distance between the suction outlet fittings no less than 3’ and no more than 20” AND either an AVS or SVRD - see Chapter 265.190 (d) (3) (A) & (B); **or** a single suction outlet with an approved cover or a grate with a minimum diagonal measurement of 24” and a flow velocity of 1.5 feet per second **AND** either an AVS or SVRD; **or** dual hydraulically-balanced suction outlets with a distance between the suction outlet fittings no less than 3’ and no more than 20”, each with a minimum diagonal measurement of 24” and a flow velocity through the open area of the grate that does not exceed 1.5 feet per second.

Pools and spas built prior to 10/1/99 greater than 4 feet deep (measured from the normal water level to the suction outlets/main drains) must have for each suction system: 2 or more hydraulically-balanced suction outlets with a distance between the suction outlet fittings no less than 3’ and no more than 20”, and with approved covers or approved grates; **or** a single suction outlet with an approved cover or an approved grate and either an AVS or an SVRD.

An approved cover is a suction outlet drain cover that is stamped with “VGB 2008”, “ASME/ANSI A112.19.8-2007” or the ASME swimmer logo, indicating it is in compliance with ASME/ANSI A112.19.8-2007 and does not have water flow through the cover that exceeds the maximum gallons per minute approved for the drain cover; and, if the manufacturer specifies fasteners, they must be stainless steel or brass.

An approved grate is a suction outlet grate that has a minimum diagonal measurement of 24”; and, has a flow velocity through the open area that does not exceed 1.5 feet per second; and, if the manufacturer specifies fasteners, they must be stainless steel or brass.

For Post 10/1/1999 Pools and Spas - See Chapter 265.190

DISINFECTION AND pH

Chlorine/bromine levels for **pools**: min. 1.0/2.5 ppm – max. 8.0/12.0 ppm

Chlorine/bromine levels for **spas**: min. 2.0/4.5 ppm – max. 8.0/12.0 ppm

pH levels for **pools and spas**: min. 7.0 – max. 7.8 (below 7.0 pH, enters acid level)

WARNING SIGNS – Where no lifeguard service is provided, warning signs must be placed in plain view which state, "WARNING – NO LIFEGUARD ON DUTY" in 4” letters, “NO DIVING” along with the **international symbol** for “no diving” in 4” letters, "CHILDREN SHOULD NOT USE POOL WITHOUT ADULT SUPERVISION" in 2” letters and “IN CASE OF EMERGENCY, CALL 911” in 1” letters (all lettering measurements are minimum height). The lettering and background on the sign must be in contrasting colors.

DEPTH MARKINGS – Depth markers shall be a minimum of 4” in height, be of contrasting color to the background, must have **permanent colors** for the numbers, units and background and be placed at 2-foot increments of depth around the pool and at minimum and maximum points of depth. Markers and units shall be slip-resistant, placed within 24” of the water’s edge and be positioned to be read while standing on the deck facing the water. **Pre-10/1/99 pools:** markers must be placed at the point of slope change from shallow end to deep end. Sidewall depth markers shall have **at least 50%** of the depth number and any unit of measurement placed above the design water level. **Post-10/1/99 pools:** markers must be spaced at not greater than 25-foot intervals with at least one marker per pool side and at the 5’ depth of a pool over 5’ deep. Units of measurement must be spelled out in “feet” or “inches” or abbreviated as “FT” or “IN”. Sidewall depth and unit markers shall be posted in the top 4.5” of the pool wall (depth indicated should be depth of water measured 3’ off of pool/spa wall).

“NO DIVING” WORDING ON DECK FOR POOLS – The warning wording “NO DIVING” and the international “no diving” symbol shall be clearly marked on the pool deck with contrasting colors and letters at least 4” high. The warning wording and symbol shall be placed at least every 25’ around the pool where the water depth is 6’ or less. The warning wording and symbol shall be slip-resistant. The warning wording and symbol shall be within 24” of the water’s edge and positioned to be read while standing on the deck facing the water. The international symbol must be red and/or black on a light background.

LIFE SAVING EQUIPMENT – Public/semi-public swimming pools must have **one of each** of the following within 20’ of the pool: a non-telescoping, 12’ minimum long, non-conductive reaching pole with an attached shepherd’s crook **AND** a United States Coast Guard approved ring buoy with an outside diameter of 15” to 24” attached to a throwing rope ¼” to 3/8” in diameter with a length at least 2/3 the maximum width of the pool. Pools with lifeguards shall have a sufficient number of rescue tubes or buoys with attached rope and shall be equipped with a first aid kit meeting OSHA requirements. First aid kits shall be a standard 24-unit kit and housed in a durable weather resistant container, kept filled and ready for use.

HIGHLIGHTS OF TEXAS HEALTH AND SAFETY CODE CHAPTER 757 – ENCLOSURES AT MULTI-UNIT RESIDENTIAL RENTAL COMPLEXES AND HOME/CONDO/PROPERTY OWNER ASSOCIATIONS (NOT ALL-INCLUSIVE).

- Pools/spas at multi-unit rental complexes or property owners associations shall be completely enclosed with a pool yard enclosure.
- The height of the pool yard enclosure must be at least 48 inches as measured from the ground on the side away from the pool.
- Openings in and under the pool yard enclosure may not allow a sphere four inches in diameter to pass through.
- The use of chain link fencing materials is prohibited entirely for a new pool yard enclosure that is constructed after January 1, 1994.
- The use of diagonal fencing members lower than 49 inches above the ground is prohibited for a new pool yard enclosure that is constructed after 1/1/94.
- Decorative designs or cutouts on or in the pool yard enclosure may not contain any openings greater than 1-3/4 inches in any direction.
- A gate in a fence or wall enclosing a pool yard must be self-closing, self-latching and open outward.

TIMEFRAMES IN WHICH DEFICIENCIES MUST BE CORRECTED

UP TO 48 HOURS	UP TO 10 CALENDAR DAYS	UP TO 30 CALENDAR DAYS
Gate not self-closing or self-latching	Missing or malfunctioning SVRD	Modifications requiring a plan review and inspection approval; i.e., enclosure, decking, etc.
Opening in enclosure thru which a small child could pass	Deepest point of floor of pool/spa not visible	
Loose or missing suction outlet cover	Non-compliant suction outlet cover	
	pH less than 7.0 or chlorine/bromine greater than 8 ppm/12 ppm (no NOV issuance or re-inspection if pool/spa undergoing hyper-chlorination)	
	Loose/dangling underwater light fixture (no confirmed exposed wiring)	
	Follow-up required to ensure permanent repair of temporarily padlocked gate(s)	
	Operating without a valid Operational Permit	



AUSTIN TRAVIS COUNTY HEALTH AND HUMAN SERVICES DEPARTMENT

Environmental Health Services Division

P.O. Box 142529 • Austin, TX 78714 • 512-978-0300 • FAX: 512-978-0322

SWIMMING POOL & SPA INSPECTION REPORT



ESTABLISHMENT: _____ ADDRESS: _____

ROW ID [] [] [] [] [] [] [] [] [] [] DIST [] [] INSP DATE MONTH DAY YEAR [] [] [] [] [] [] [] [] TIME IN [] [] [] [] TIME OUT [] [] [] []

PERMIT EXPIRES []

INSPECTION TYPE:
[] Annual Inspection [] Re-inspection [] Complaint/follow-up [] Consult

- POOL: 1. Chlorine/Bromine content: _____ (see back of form)
2. pH Level: _____ (see back of form)
3. Water temperature is acceptable (maximum 104°F) and thermometer present (see back of form):..

THE FOLLOWING APPLIES TO BOTH POOLS AND SPAS:

- 4. All suction outlets have approved anti-vortex covers/grates; present and secured:
5. Suction outlets meet main drain and SVRS requirements (see back of form):
6. Water is clear, clean and free of algae; the main drain(s) are visible:
7. Gate(s)/enclosure meets requirements; gate(s) self-closing and self-latching (see back of form):
8. Underwater lighting mounted and secured:
9. Equipment appears to be in good working order (electrical, leaking equipment, air leaks, etc):
10. Daily water quality testing of pool and spa being performed and documentation available:
11. Backflow prevention devices are present on all spigots/hose bibs in and around pool yard:
12. Sidewall and deck-top depth markings are present and meet requirements (see back of form):
13. Deck-top "No Diving" wording and symbols present and meet requirements (see back of form):
14. 4" row of tile or painted line indicating transition point from the shallow area to the deep area:
15. Warning Signs conspicuously posted (see back of form for details):
16. Lifesaving equipment is provided and meets requirements (see back of form for details):
17. Emergency telephone readily accessible within 200'; location and signage requirements are met:

NOTE: The pool owner is responsible for ensuring that the pool yard enclosure is in compliance with Chapter 757 of the Texas Health and Safety Code. The pool operator must inspect all gates and enclosures at least every 31 days.

*THE FOLLOWING CONDITIONS REQUIRE IMMEDIATE CLOSURE OF POOL OR SPA:

- The main drain covers/grates are missing/unsecured Main drain(s) do not meet Chapter 265.190
Main drain(s) not visible Gate/enclosure needs repair or does not meet requirements
Chlorine/Bromine level of greater than 8 ppm/12 ppm pH is less than 6.8 Presence of fecal matter
Bottom of pool/spa not visible Underwater pool light(s) missing/unsecured Operating without a permit

The pool may only be re-opened by a representative of the Health Department after item(s) have been corrected.

\$135 RE-INSPECTION FEE REQUIRED? [] YES [] NO

CALL 978-0300 TO SCHEDULE A RE-INSPECTION WITHIN TIME SPECIFIED.

Inspected by: _____ Received by: _____

Comments: _____

MAIN DRAIN/SUCTION OUTLET AND SVRS REQUIREMENTS EFFECTIVE JANUARY 1, 2005

Pools and spas built prior to 10/1/99 that are 4 feet deep or less (as measured from the normal water level to the suction outlets/main drains) must have for each suction system: two or more hydraulically balanced suction outlets with approved covers (defined below) or approved grates (defined below) with a distance between the suction outlet fittings no less than 3 feet and no more than 20 feet AND either an AVS or SVRD - see Chapter 265.190 (d) (3) (A) & (B); **or** a single suction outlet with an approved cover or a grate with a minimum diagonal measurement of 24 inches and a flow velocity of 1.5 feet per second **AND** either an AVS or SVRD; **or** dual hydraulically-balanced suction outlets with a distance between the suction outlet fittings no less than 3 feet and no more than 20 feet, each with a minimum diagonal measurement of 24 inches and a flow velocity through the open area of the grate that does not exceed 1.5 feet per second.

Pools and spas built prior to 10/1/99 greater than 4 feet deep (as measured from the normal water level to the suction outlets/main drains) must have for each suction system: two or more hydraulically-balanced suction outlets with a distance between the suction outlet fittings no less than 3 feet and no more than 20 feet, and with approved covers or approved grates; **or** a single suction outlet with an approved cover or an approved grate and either an AVS or an SVRD.

An approved cover is a suction outlet drain cover that is stamped with "VGB 2008", "ASME/ANSI A112.19.8-2007" or the ASME swimmer logo, indicating it is in compliance with ASME/ANSI A112.19.8-2007 and does not have water flow through the cover that exceeds the maximum gallons per minute approved for the drain cover; and, if the manufacturer specifies fasteners, they must be stainless steel or brass.

An approved grate is a suction outlet grate that has a minimum diagonal measurement of 24 inches; and, has a flow velocity through the open area that does not exceed 1.5 feet per second; and, if the manufacturer specifies fasteners, they must be stainless steel or brass.

For Post 10/1/1999 Pools and Spas - See Chapter 265.190

DISINFECTION, pH AND TEMPERATURE:

Acceptable chlorine/bromine levels for **pools**: min. 1.0/2.5 ppm – max. 8.0/12.0 ppm

Acceptable chlorine/bromine levels for **spas**: min. 2.0/4.5 ppm – max. 8.0/12.0 ppm

Acceptable pH levels for **pools and spas**: min. 7.0 – max. 7.8 (below 7.0 pH, enters acid level)

Water temperature in Spas is acceptable (**maximum 104°F**)

WARNING SIGNS – Where no lifeguard service is provided, warning signs must be placed in plain view which state, "WARNING – NO LIFEGUARD ON DUTY" in 4" letters, "NO DIVING" along with the **international symbol** for "no diving" in 4" letters, "CHILDREN SHOULD NOT USE POOL WITHOUT ADULT SUPERVISION" in 2" letters and "IN CASE OF EMERGENCY, CALL 911" in 1" letters (all lettering measurements are minimum height). The lettering and background on the sign must be in contrasting colors.

DEPTH MARKINGS – Depth markers shall be a minimum of 4" in height, be of contrasting color to the background, must have **permanent colors** for the numbers, units and background and be placed at 2-foot increments of depth around the pool and at minimum and maximum points of depth. Markers and units shall be slip-resistant, placed within 24" of the water's edge and be positioned to be read while standing on the deck facing the water. **Pre-10/1/99 pools**: markers must be placed at the point of slope change from shallow end to deep end. Sidewall depth markers shall have **at least 50%** of the depth number and any unit of measurement placed above the design water level. **Post-10/1/99 pools**: markers must be spaced at not greater than 25-foot intervals with at least one marker per pool side and at the 5' depth of a pool over 5' deep. Units of measurement must be spelled out in "feet" or "inches" or abbreviated as "FT" or "IN". Sidewall depth and unit markers shall be posted in the top 4.5" of the pool wall (depth indicated should be depth of water measured 3' off of pool/spa wall).

"NO DIVING" WORDING ON DECK FOR POOLS – The warning wording "NO DIVING" and the international "no diving" symbol shall be clearly marked on the pool deck with contrasting colors and letters at least 4" high. The warning wording and symbol shall be placed at least every 25' around the pool where the water depth is 6' or less. The warning wording and symbol shall be slip-resistant. The warning wording and symbol shall be within 24" of the water's edge and positioned to be read while standing on the deck facing the water. The international symbol must be red and/or black on a light background.

LIFE SAVING EQUIPMENT – Public/semi-public swimming pools must have **one of each** of the following within 20' of the pool: a non-telescoping, 12' minimum long, non-conductive reaching pole with an attached shepherd's crook **AND** a United States Coast Guard approved ring buoy with an outside diameter of 15" to 24" attached to a throwing rope 1/4" to 3/8" in diameter with a length at least 2/3 the maximum width of the pool. Pools with lifeguards shall have a sufficient number of rescue tubes or buoys with attached rope and shall be equipped with a first aid kit meeting OSHA requirements. First aid kits shall be a standard 24-unit kit and housed in a durable weather resistant container, kept filled and ready for use.

HIGHLIGHTS OF TEXAS HEALTH AND SAFETY CODE CHAPTER 757 – ENCLOSURES AT MULTI-UNIT RESIDENTIAL RENTAL COMPLEXES AND HOME/CONDO/PROPERTY OWNER ASSOCIATIONS (not all-inclusive).

- Pools/spas at multi-unit rental complexes or property owners associations shall be completely enclosed with a pool yard enclosure.
- The height of the pool yard enclosure must be at least 48 inches as measured from the ground on the side away from the pool.
- Openings in and under the pool yard enclosure may not allow a sphere four inches in diameter to pass through.
- The use of chain link fencing materials is prohibited entirely for a new pool yard enclosure that is constructed after 1/1/94.
- The use of diagonal fencing members lower than 49 inches above the ground is prohibited for a new pool yard enclosure that is constructed after 1/1/94.
- Decorative designs or cutouts on or in the pool yard enclosure may not contain any openings greater than 1-3/4 inches in any direction.
- A gate in a fence or wall enclosing a pool yard must be self-closing, self-latching and open outward.

TIMEFRAMES IN WHICH DEFICIENCIES MUST BE CORRECTED

UP TO 48 HOURS	UP TO 10 CALENDAR DAYS	UP TO 30 CALENDAR DAYS
Gate not self-closing or self-latching	Missing or malfunctioning SVRD	Modifications requiring plan review and inspection approval; i.e., enclosure, decking.
Opening in enclosure thru which a small child could pass	Deepest point of floor of pool/spa not visible	
Loose or missing suction outlet cover	Non-compliant suction outlet cover	
Exposed wiring/electrocution hazard (on under-water light fixture, in pump room, etc)	pH less than 7.0 or chlorine/bromine greater than 8 ppm/ 12 ppm (no NOV issuance or re-inspection if pool/spa undergoing hyper-chlorination)	
	Loose/dangling underwater light fixture (no confirmed exposed wiring or no power to fixture)	
	Follow-up required to ensure permanent repair of temporarily padlocked gate(s)	
	Operating without a valid Operational Permit	

**THE FOLLOWING STANDARDS ARE REQUIRED FOR ALL PIWFF'S
OWNERS/OPERATORS ARE RESPONSIBLE FOR KNOWLEDGE OF CODES –
THIS IS NOT AN ALL-INCLUSIVE LIST**

PUBLIC INTERACTIVE WATER FEATURE AND FOUNTAIN (PIWFF) - Any indoor or outdoor installation designed and maintained for public recreation/water contact that includes water sprays, dancing water jets, waterfalls, dumping buckets, or shooting water cannons. A PIWFF does not include installations located on **private property** serving a single-family residence or duplex.

REQUIRED DISINFECTION AND pH LEVELS

Acceptable chlorine/bromine levels	Min. 1.0/2.5 ppm – max. 8.0/12.0 ppm
Acceptable pH levels	Min. 7.0 – max. 7.8 (below 7.0 pH is an acid level)
Cyanuric Acid (Stabilizer) <i>Out-of-Door Facilities Only</i>	Ideal = 20 ppm (no minimum requirement) Maximum = 50 ppm

A water quality testing device or kit (DPD kit required) capable of measuring pH and free chlorine or bromine shall be provided by the operator when requested by the inspector.

TESTING FREQUENCY REQUIREMENTS

pH and Disinfection:

- at least once each day while in operation if equipped with automatic continuous disinfectant and pH feed equipment that continually monitors and automatically controls disinfection and pH;
- at least twice per day while in operation if not equipped with automatic disinfectant/pH feed and monitoring/control equipment. Once immediately prior to opening the PIWFF and once midway through the period of time it is open for use.

Cyanuric Acid:

Tests for cyanuric acid levels shall be conducted at least once every 7 days of operation when chlorine containing stabilizer is in use.

NOTE: Forms of chlorine containing cyanuric acid shall not be used in **INDOOR PIWFF'S**.

WARNING SIGNS - Warning signs shall be posted at the entrance of all PIWFFs, or where the signs are clearly visible to users entering the PIWFF area before contact with PIWFF water occurs while open for use. Signs shall be securely mounted, clearly visible, and easily read with letters in contrasting color to the background. The required sign can be placed on a single sign. The signage shall provide the following notifications in letters at least 2 inches in height:

- "Non-Service Animals Prohibited"
- "Changing Diapers Within 6 Feet Of The Water Feature is Prohibited"
- "Use Of The Water Feature If Ill With A Contagious Disease is Prohibited"
- "Do Not Drink Water From The Water Feature"
- "Use Of The Water Feature When Ill With Diarrhea is Prohibited"

❖ **Signage requirements for PIWFF's with no on-site operator** - a sign shall be posted that provides a contact number to be used in the event of an issue requiring correction at the PIWFF.

OPERATING PERMIT EXCEPTION - No Operating Permit is required by this Department for PIWFF'S using freshwater which originates from a natural watercourse for recreational purposes and releases the freshwater back into the natural water course **or** for fountains, installations, amusement rides, or other attractions, whether decorative or interactive, in which only incidental water contact occurs.

SUCTION OUTLET DEVICE REQUIREMENTS - PIWFF's with water reservoirs or basins that are accessible to users **may** be subject to the suction outlet device requirements of TAC §265.187. Contact this Department for any questions re: suction device requirements.

PIWFF OPERATOR TRAINING/CERTIFICATION - PIWFF's shall be operated/maintained under the supervision of a properly trained/certified operator. The operator shall provide a current certification upon request by this Department. Training/certification shall be obtained by completion of any of the following courses: "Aquatic Facility Operator", "Certified Pool Operator", "Licensed Aquatic Facility Technician", or AquaTech Pool and Aquatic Facility Operator.

TURNOVER RATES - If constructed prior to 5/1/10, the minimum design turnover rate specific to the particular PIWFF. If constructed/extensively remodeled on or after 5/1/10, at least once every hour.

SUPPLEMENTAL WATER TREATMENT SYSTEM

Stand-Alone PIWFF'S:

Post-5/1/10 - shall be equipped with a supplemental water treatment system that protects the public against *Cryptosporidium* using any of the following: UV light disinfection installed after filtration, ozone, a NSF/ANSI-50 product to control *Cryptosporidium*, **weekly** hyperchlorination following the CSC's recommendations, or an equivalent process/method approved by this Department.

Pre-5/1/10 PIWFF's - shall either be equipped with a supplemental water treatment system **OR** the water of the PIWFF shall be tested for *Cryptosporidium* every **14 days** while in operation.

PIWFF'S Sharing Water with Swimming Pool/Spa:

Pre-5/1/10 - shall implement a supplemental water treatment system that protects the public against *Cryptosporidium* **OR** test the water for *Cryptosporidium* every 30 days during operation.

Post-5/1/10 - shall implement a supplemental water treatment system that protects the public against *Cryptosporidium*.

TESTING/MONITORING RECORDS FOR PIWFF'S - The following records shall be kept for a minimum of 2 years and be made available during inspection by this Department (if kept off-site, they shall be provided within 5 working days following request): daily chemical log; disinfection, cyanuric acid, and pH test results; maintenance schedule; documentation that circulation equipment meets the NSF/ANSI-50 Standard, if applicable; manufacturer's instructions for operation of the disinfection equipment, chemical control equipment, and chemical feed system; documentation of the following: turnover rate (must meet the requirements), any required *Cryptosporidium* testing, supplemental water treatment, and the date of construction of the PIWFF.



SIPPO/MATTO INSPECTION REPORT/NOTICE OF VIOLATION

DATE: _____

ESTABLISHMENT: _____ ADDRESS: _____

Complaint Investigation Follow-Up Investigation Routine FS Consultation

VIOLATIONS OBSERVED: (a circled "Y" indicates a violation is observed)

1.	Y	Smoking observed in a public place or workplace in which smoking is prohibited in violation of §10-6-2.
2.	Y	Failure by operator to take necessary steps to prevent or stop another person from smoking in an enclosed area in a public place as per §10-6-2(E).
3.	Y	Failure to conspicuously post signs at each entrance and in the public place/workplace as per §10-6-8(A).
4.	Y	Failure to remove ashtrays from a place where smoking is prohibited as per §10-6-8(C).
5.	Y	Smoking observed within 15 ft. of a door or openable window of an enclosed area in which smoking is prohibited in violation of §10-6-2(D).
6.	Y	Failure to provide a smoke-free workplace for employees as per §10-6-5 – <i>reported by employee(s)</i> .
7.	Y	Failure to post the Minor's Access to Tobacco Warning Notice as required as per §10-4-4.
8.	Y	Failure to prohibit self-service merchandising of tobacco products in an establishment which permits minors as per §10-4-12.
9.	Y	Observed installation or maintenance of a tobacco vending machine in violation of §10-4-13.
10.	Y	Other:

LEGAL NOTICE: Violations indicated above must be corrected immediately. Failure to comply with the City of Austin Code of Ordinances Ch. 10-6 or 10-4 **may result in legal action taken against the responsible party.**

OPERATOR'S MINIMUM RESPONSIBILITIES FOR TAKING "NECESSARY STEPS"

1. Post "NO SMOKING" signs and/or the international symbol for "NO SMOKING" ☹ and remove all ashtrays.
2. Verbally (sign interpretation or in written form for the hearing impaired) inform the person who is smoking that smoking is not allowed in establishment and ask them to extinguish their cigarette, cigar, smoking apparatus, etc.
3. *If a person continues to smoke after steps 1 and 2 have been taken, then* verbally (sign interpretation or in written form for the hearing impaired) advise them that they are in violation of SIPPO and that both the person *and* the owner/operator could be issued a citation by the Health Department.
4. *If a person continues to smoke after steps 1 thru 3 have been taken, then* discontinue service to them.
5. *If a person continues to smoke after steps 1 thru 4 have been taken, then* verbally (sign interpretation or in written form for the hearing impaired) ask them to leave the establishment.
6. *If a person continues to smoke after steps 1 thru 5 have been taken, then* apply standard business procedures as when other illegal activities or violations of house rules **are** committed by individuals/patrons which require intervention by the establishment's operator and/or staff to prevent or stop.

COMMENTS:

Received By: (Print legibly) _____	Title: _____
Received By: (Sign) _____ I acknowledge receipt of this notice and understand it is not an admission of guilt by signing it. I am the person named and identified in this notice.	Inspected By: _____



AUSTIN/TRAVIS COUNTY HEALTH AND HUMAN SERVICES DEPARTMENT
ENVIRONMENTAL HEALTH SERVICES DIVISION
Rodent and Vector Program
P.O. Box 142529, Austin, TX 78714
Phone: (512) 978-0370 • Fax: (512) 978-0322



Environmental Health Services Division
Field Inspection Report

Date: _____ Time: _____

Address: _____ Zip: _____

Legal Description (if necessary): _____

COPY OF ORDINANCE PROVIDED? Yes No N/A

EDUCATIONAL MATERIALS (PAMPHLET/FLYER) PROVIDED? Yes No N/A

EHSD Program Staff Signature

Customer Signature

**Austin/Travis County Health and Human Services Department
FOOD MANAGER CERTIFICATE**



Awarded to

for having met all of the requirements prescribed by Section 10-3-31 of the City of Austin, Code of Ordinances including successful completion of a food management examination that has been approved by the Texas Department of State Health Services.

Date

Health Authority

Certificate Number

Expiration Date

Instructor



12630608

POPULATION RISKS

- Low Income
- Inner-city resident
- Foreign born
- Binational (US-Mexico)

- *Within past year
- Correctional employee*
 - Health Care Worker*
 - Prison/Jail inmate*
 - Long-term facility for elderly/resident*
 - Health care facility/resident*
 - Shelter for homeless persons*
 - Migrant farm worker*
 - Dorm/Resident
 - Colonia/Resident
 - None of the above risks apply

MEDICAL RISKS

- Diabetes mellitus I II
- Alcohol Abuse (within past year)
- Tobacco use
- Silicosis
- Corticosteroids or other immunosuppressive therapy
- Gastrectomy or jejunoileal bypass
- age < 5 years
- Recent exposure to TB (contact to TB case)
- Contact to MDR-TB case
- Weight at least 10% less than ideal body weight
- Chronic metabsorption syndromes
- Leukemia
- Contact of Infectious TB
- Missed Contact
- Incomplete LTBI Therapy
- TNF Therapy
- Obesity
- Immunosuppression (not 900)
- Lymphoma
- Cancer of head
- Cancer of neck
- Drug abuse within past year:
 - Injecting
 - Unknown if injecting
 - Non-injecting
- HIV seropositive (check only if laboratory)
- Tuberculin skin test conversion within 2 years
- Fibrotic lesions (on chest x-ray) consistent with old, healed TB
- Chronic renal failure
- Organ Transplant

- Other
- None of these medical risks apply

HIV TEST RESULTS

Date HIV Test: [] / [] / []

Positive Refused

Negative Not Offered

Pending

Date CD4 Count: [] / [] / []

Results CD4 Count: [] [] []

Rapid Conventional

Immigration Status at First Entry to the US: Not Applicable Immigrant Visa Tourist Visa Family/Fiance Visa Asylee or Parolee

Student Visa Employment Visa Refugee Visa Unk Other

-US Born/born abroad to a parent who was a US citizen
-Born in US Territory, US Island Area, US Outlying Area

TUBERCULIN SKIN TEST

Documented History of Positive TST? Yes No

[] / [] / [] mm Positive Negative Not Read Not Done

[] / [] / [] mm Positive Negative Not Read Not Done

Test Place: []

Test Place: []

PRIOR LTBI Treatment? Yes No Start Date: [] / [] / [] Stop Date: [] / [] / []

FOR TREATMENT OF LTBI ONLY

CT Scan Radiograph Other Chest imaging Date: [] / [] / [] Normal Abnormal (Not Suggestive of TB)

DOPT: Yes, totally observed No, self-administered Both Was Treatment Recommended? Yes No

DOPT Site: Clinic or medical facility Field Both

Frequency: Daily Twice Weekly Three X's Weekly

Weight: [] [] [] Height: [] [] Medication Change Date: [] / [] / []

Date Regimen Start: [] / [] / [] Date Regimen Stop: [] / [] / [] Prescribed for (months): []

Date Regimen Restart: [] / [] / [] Date Regimen Stop: [] / [] / [] Maximum refills authorized: []

IGRA TEST

Test Date: [] / [] / []

Test Type: QFT T-SPOT Other

Positive Not Done Negative Unknown Indeterminate

Result: [] [] Percent: [] []

Dosage	Unit	Duration in weeks	Dosage	Unit	Duration in weeks
<input type="checkbox"/> Isoniazid	[] []	[] []	<input type="checkbox"/> Other (specify)	[] []	[] []
<input type="checkbox"/> Rifampin	[] []	[] []	<input type="checkbox"/> Other (specify)	[] []	[] []
<input type="checkbox"/> B6	[] []	[] []			

ATS CLASSIFICATION

- 0 No M, TB Exposure, Not TB infected
- 1 M, TB Exposure, No evidence of TB infection
- 2 M, TB Infection, No Disease
- 4 M, TB, No Current Disease

Physician Signature Date: [] / [] / [] Physician Signature: []

CLOSURE

Provider Decision: Pregnant Non - TB Date: [] / [] / [] Close Episode? Yes No # months on Rx: [] # months recommended: []

Lost to followup Deceased Deceased Cause: [] Death Date: [] / [] / []

Patient chose to stop Moved out of state/country Country State/Name: []

Adverse drug reaction Other Other Reason: []

Completion of adequate therapy

GENERAL COMMENTS: []

Austin/Travis County Health Department
Tuberculosis Elimination Division
Report of Case and Patient Services



12152354

Appointment Date
[]/[]/[]

Appointment Time
[]:[] AM PM

Date reported to Health Department
[]/[]/[]

CI [] NCM []

Date form sent to region
[]/[]/[]

Date form sent to central office
[]/[]/[]

Initial Report Drug Resistance Followup or Medical Review Hospital Admission or Discharge New Classification/Change

Social Security Number []-[]-[] Date of Birth (mm/dd/yyyy) []/[]/[] Phone Number ([]) []-[] Home Work Cell

Last Name [] Suffix [] Sex: Male Female

First Name [] Middle Name []

Address [] Apartment Number []

City [] County [] Zip Code []

Facility/Care Provider Name [] Name of person completing this form []

Facility responsible for patient care: Public Health Clinic Private Physician Public Hospital TDCJ Military Hospital VA Other (Specify) []

Signs/Symptoms at DX
Fever Y N [] weeks
Chills Y N [] weeks
Cough Y N [] weeks
Lymph Node Y N [] weeks
Productive Cough Y N [] weeks
Hemoptysis Y N [] weeks
Night Sweats Y N [] weeks
Weight Loss (>10%) Y N [] weeks
Other: []

Status New Recurrent Reopen
Prior Therapy? Yes No
Start Date []/[]/[]
Stop Date []/[]/[]

ATS Classifications
 0 No M, TB Exposure, Not TB Infected
 1 M, TB Exposure, No Evidence of TB Infection
 2 M, TB Infection, No Disease
 3 M, TB, Current Disease
 4 M, TB, No Current Disease
 5 M, TB Suspect, Diagnosis Pending

Culture Results
Current Collect Date []/[]/[]
Current Report Date []/[]/[]
Specimen Type: sputum urine biopsy
 bronchial washing other
If biopsy or other, list anatomic site of specimen []
Sputum culture conversion documented?
 Yes No NA If no, reason: []

Chest X-Ray
 CT Scan Radiograph Other Chest Imaging
Date []/[]/[]
Result Normal Abnormal Unknown Not Done
 Not suggestive of TB
If Abnormal: Cavitory (check abnormality) Non-cavitory, (consistent with TB) Non-cavitory, (not consistent with TB)
If Abnormal, evidence of Miliary TB? Yes No UNK
If Abnormal, (check status) Stable Worsening Improving UNK

Significant Sites (Class 3, 5) (select all that apply)
 Pulmonary Laryngeal
 Pleural Bone and/or Joint
 Lymphatic: Cervical Genitourinary
 Lymphatic: Intrathoracic Meningeal
 Lymphatic: Axillary Peritoneal
 Lymphatic: Other Site Not Stated
 Lymphatic: Unknown Other: Specify []
Specify other significant sites []
From the selected significant sites, Primary Site is: []

Result
 Negative Positive for M.TB Positive for Non-M.TB
 Pending Not done
If Positive, Bacteria Type []
LabType
 ATCHHSD DSHS State Lab Lab Corp
 Clinical Pathology Lab Hospital Lab Private Lab

If Pediatric TB Case (<15 Years Old) Country of birth for primary guardians:
Guardian 1 []
Guardian 2 []
Patient lived outside US for >2 months: Yes No Unknown
If yes, Country []
Chest X-Ray Comments: []

AFB Smear Results
Current Collect Date []/[]/[]
Current Report Date []/[]/[]
Specimen Type sputum urine biopsy
 bronchial washing other
If biopsy or other, list anatomic site of specimen []
If other than sputa, type of exam:
 Smear Pathology Cytology
LabType
 ATCHHSD DSHS State Lab Lab Corp Clinical Pathology Lab Hospital Lab Private Lab
Result
 Negative Positive Pending Not done

Nucleic Acid Amplification Test
Current Collect Date []/[]/[]
Current Report Date []/[]/[]
TestType: MTD PCR
Specimen Type sputum urine biopsy bronchial washing other
If biopsy or other, list anatomic site of specimen []
LabType
 ATCHHSD DSHS State Lab Lab Corp Clinical Pathology Lab Hospital Lab Private Lab
Result
 Negative Positive Indeterminate Not done

Genotyping: Isolate Submitted for genotyping? Yes No Episode Genotyping Accession Number []

Susceptibility Results

12152354

Current Collect Date

____ / ____ / ____

Specimen Type: sputum urine biopsy bronchial washing other

If biopsy or other, list anatomic site of specimen

Current Report Date

____ / ____ / ____

LabType

Culture was sensitive to:

Isoniazid Rifampin Ethambutol Other Quinolones

Culture was resistant to:

Isoniazid Rifampin Ethambutol Other Quinolones

ATCHHSD DSHS State Lab Lab Corp Clinical Pathology Lab Hospital Lab Private Lab

TREATMENT FOR ACTIVE TB DISEASE

Date Regimen Start

____ / ____ / ____

Date Regimen Stop

____ / ____ / ____

Weight

____ . ____

Prescribed for (months): Maximum refills authorized:

____ / ____

Date Regimen Restart

____ / ____ / ____

Date Regimen Stop

____ / ____ / ____

Height

Medication Change Date

____ / ____ / ____

Isoniazid Rifampin Ethambutol Other Quinolones

Dosage Unit Duration (In weeks)

Rifater Levofloxacin Gatifloxacin Moxifloxacin Rifapentene Clofazimine Cycloserine PAS B6

Directly Observed Therapy (DOT) Doses DOT Frequency
 Yes, totally observed Daily
 No, self-administered Twice Weekly
 Both Three X's Weekly

If No, self-administered, specify reason

DOT Site

Clinic or medical facility DOT/Field Both

Control Order

____ / ____ / ____

Court Action

____ / ____ / ____

Chest Xray Return

____ / ____ / ____

Reason Therapy Extending > 12 months

TB Not Enrolled Yes No Compliant Yes No

Hospitalization Advised Yes No Consult Yes No

Quarantine Advised Yes No Quarantine Location: _____

Collect next sputum on

____ / ____ / ____

Other Lab Studies

____ / ____ / ____

Return to Nurse clinic on

____ / ____ / ____

Return to MD clinic on

____ / ____ / ____

CLOSURE

Date

____ / ____ / ____

Close Episode? Yes No

% doses taken by DOT

doses taken

doses recommended

months on Rx

months recommended

Lost to followup

Provider Decision: Pregnant Non - TB

Patient chose to stop

Deceased

Deceased Cause:

Death Date

____ / ____ / ____

Adverse drug reaction

Moved out of state/country

Country State/Name:

Date referred to Austin

____ / ____ / ____

Completion of adequate therapy

Other

Other Reason:

GENERAL COMMENTS:

Authorized Nurse to Obtain Informed Consent

Yes

Nurse Signature

Nurse Signature Date

____ / ____ / ____

Physician Signature

Physician Signature Date

____ / ____ / ____



**Austin/Travis County Health & Human Services
Communicable Disease Unit, TB/STD
15 Waller St., Austin, TX. 78702
(512) 972-5460 (512) 972-5430**

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the Austin/Travis County Health & Human Services Department to (circle one) release/obtain medical information concerning:

Patient Name: _____ Date of Birth ____/____/____ Dates of Service: _____

Address: _____ City _____ State _____ Zip _____

Soc. Sec. No ____/____/____ Telephone Number: _____ Cell: _____

This information is to be released to/obtained from (circle one)

Facility / Person _____

Address _____

City/State _____ Zip _____

Telephone Number _____

Return Address

Facility _____

Address _____

City/State _____ Zip _____

Telephone Number _____

Please release the following information, indicated by an "X":

- | | | |
|---|---|---|
| <input type="checkbox"/> Progress/Clinic Notes | <input type="checkbox"/> Consultation | <input type="checkbox"/> Hospital Summary Sheet |
| <input type="checkbox"/> Lab Results/X-Rays | <input type="checkbox"/> History & Physical | <input type="checkbox"/> Operative Report (s) |
| <input type="checkbox"/> Tuberculosis Elimination Records | <input type="checkbox"/> Discharge Summary | |
| <input type="checkbox"/> Social Work Notes | <input type="checkbox"/> Other _____ | |

- | | |
|--|-------------------|
| <input type="checkbox"/> HIV/STD
Medical
Information | Initials
_____ |
| <input type="checkbox"/> Psychiatric | _____ |
| <input type="checkbox"/> Substance Abuse
Records | _____ |

This information is necessary for the following purposes:

- | | | | |
|---|---|--|-------------------------------------|
| <input type="checkbox"/> Follow-up Care | <input type="checkbox"/> Patient is requesting disclosure | <input type="checkbox"/> Disability Benefits | <input type="checkbox"/> Attorney** |
| <input type="checkbox"/> Other** Please Explain _____ | **Indicates Fee for Service | | |

Will Financial/compensation result in use or disclosure? Yes No

Please release my information via: Mail Orally Pick-up Fax (Emergencies Only) (Fax No. _____)

I, the undersigned, understand that I may revoke this consent at any time in writing, except to the extent that action has been taken in reliance on it and that in any event this consent shall expire in six (6) months from when it is signed unless otherwise specified (Otherwise specified date _____). Upon expiration, the ATCHHSD can no longer use or disclose my information for the above purposes without a new authorization. All revocations will be sent to the attention of the Clinic Manager and become effective once received.

I understand that the above information may include records/reports from other health care providers involved in my care or treatment. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information and the recipients(s) of that information.

I understand any of the above requested information may include results of sexually transmitted disease, acquired immunodeficiency syndrome(AIDS) Human Immunodeficiency Virus (HIV) tests if any were performed. Further, I understand any of the above requested information may include results of alcohol/drug (substance) abuse and/or diagnosis and treatment of psychological disorders.

I understand that the provision of my health care and the payment for my health care will not be affected if I do not sign this form. You may refuse to sign this authorization.

I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it

- FOR OFFICE USE ONLY:** Authorization added to the patient's medical record on _____.
- Authorization verified by _____ on _____.
- Patient has been provided with a copy of the signed authorization.

THE PARTY RECEIVING THIS INFORMATION: This information is being disclosed to you from records where confidentiality may be protected by federal and/or state laws. If so, regulations 42 CFR, Part 2, prohibit further disclosure without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation.

Signature of Patient or Authorized Party _____	Date _____	Relationship to Patient _____
Witness _____	Reason for Patient Not Signing _____	

White: Medical Records Yellow: Request Records Pink: Patient Copy



**Austin/Travis County Health & Human Services
Communicable Disease Unit, TB/STD
15 Waller St., Austin, TX. 78702
(512) 972-5460 (512) 972-5430**

AUTORIZACIÓN PARA LIBERAR INFORMACIÓN MÉDICA

Yo autorizo a Austin/Travis County Departamento de los Servicios de Cuidado a liberar/obtener (marque una) información médica acerca de:

Nombre del Paciente: _____ Fecha de Nacimiento ____/____/____

Dirección de Domicilio: _____ Ciudad _____ Estado _____ Zip _____

No de Soc. Sec. ____/____/____ Número de Teléfono: _____ Fechas de Servicio: _____

Esta información va a ser liberada para/obtenida de (marque una):

Nombre _____

Dirección _____

Ciudad/Estado _____ Código Postal _____

Número de Teléfono _____

Dirección de regreso:

Nombre _____

Dirección _____

Ciudad/Estado _____ Código Postal _____

Número de Teléfono _____

Por favor libere la siguiente información indicada con una "X":

Informe del progreso clínico Consultas Sumario del Expediente

Resultados de Laboratorio/
Rayos X Historia y Exámen Físico Reported de Operación(es)

Registro de Eliminación de
Tuberculosis Sumario de Egreso

Notas de Trabajo Social Otro _____

Yo doy permiso especial para liberar
Cualquier información en cuanto
a los siguiente **INICIAL**
 Información Médica
del VIH
 Psiquiatría
 Registro de Abuso de
Sustancias

Esta información es necesaria por los siguientes propósitos:

Completar el Cuidado Médico El Paciente Solicita la Divulgación Beneficios de Incapacidad Abogado**

Otra ** Por favor explique _____ ****Indica un precio monetario por estos servicios**

Resultará en un beneficio financiero/compensación el uso o divulgación?: Si No

Por favor libere mi información via: Correo Postal Oralmente Recoger Fax (en casos de Emergencia)

(No. de Fax _____)

El paciente, o el representante del paciente, debe leer la siguiente declaración

Yo, el abajo firmante, entiendo que puedo revocar este consentimiento por escrito en cualquier momento a excepción que hasta cierto punto la acción haya sido tomada en confianza y que en cualquier evento este consentimiento expirará en (6) meses de la fecha en cual esta es firmada, a menos que otra fecha haya sido especificada (Otra fecha especificada _____). Yo, entiendo que el suministro y los pagos para mi cuidado de salud no serán afectados si decido no firmar esta forma. Al expirarse, el Departamento de los Servicios de Cuidado de la Communicable Disease, no podrá usar o liberar mi información para los propósitos nombrados arriba sin una nueva autorización. Todas las revocaciones serán enviadas a la atención del Oficial de Privacidad del Communicable Disease y una vez recibidas se pondrán en efecto.

Yo entiendo que tal información puede incluir documentos/reportes de pasados proveedores de salud involucrados en mi cuidado o tratamiento. Yo he leído esta autorización y entiendo cual información sera usada o divulgada, quien puede usar y revelar la información y los destinatarios de la tal.

Yo entiendo que cualquiera de la información requerida arriba puede incluir resultados de exámenes de enfermedades transmitidas sexualmente, syndrome de inmunodeficiencia adquirida (SIDA), Virus de Inmunodeficiencia Humana (VIH) si algunos fueron hechos. Además, yo entiendo que cualquiera de la información requerida arriba puede incluir resultados de alcohol y drogas (abuso de sustancias) y/o diagnóstico y tratamiento de desordenes psicológicos.

Yo entiendo que puedo ver y obtener una copia de la información descrita en este formulario si pido por ella, y que puedo obtener una copia de este formulario después de haberlo firmado.

PARA USO DE OFFICINA SOLAMENTE:

- Autorización añadida a el registro medico del paciente el día _____.
- Autorización fue verificada por _____ el día _____.
- El paciente fue proveído con una copia de la autorización firmada.

PARA EL PARTIDO QUE RECIBE ESTA INFORMACION: Esta información es divulgada a usted de registros donde la confidencialidad del individuo es protegida bajo leyes federales y estatales. Si es así, Parte 2 de las regulaciones 42 C.F.R., prohíbe ninguna divulgación adicional sin el consentimiento escrito del individuo a quien la información pertenece, o de otra manera, como es permitido por tal regulación.

Firma del paciente o Partido Autorizado

Fecha

RELACIÓN al Paciente

Testigo _____ Razón a la cual el Paciente no Firmó _____

LAB ORDER and REPORT FORM

To Order Check Box to Left of Test

Tests Declined: _____

← Check This Column

Patient Signature: _____

<input type="checkbox"/> Rapid HIV Ag/Ab Combo	___ Nonreactive (N*) ___ Ag Reactive ___ Ab Reactive ___ Indeterminate (Resubmit new sample)	_____
		Tech Initials
<input type="checkbox"/> RPR	___ Nonreactive (N*) ___ Reactive Titer: _____	_____
		Tech Initials
<input type="checkbox"/> SHC	___ Nonreactive (N*) ___ Reactive ___ Invalid (Resubmit new sample)	_____
		Tech Initials
<input type="checkbox"/> HCV	___ Nonreactive (N*) ___ Reactive ___ Invalid (Resubmit new sample)	_____
		Tech Initials
<input type="checkbox"/> Gram Stain	URETHRA/CERVICAL ___ WBC seen ___ No Gram negative diplococci observed (N*) →→ ___ Negative (N*) ___ Gram negative intracellular diplococci observed →→ ___ Positive ___ Gram negative extracellular diplococci observed →→ ___ Suspicious	_____
		Tech Initials
<input type="checkbox"/> KOH/Wet Prep	WBCS ___ Negative(N*) ___ Negative Clue Cells ___ Negative ___ Negative Whiff ___ Negative ___ Positive Yeast ___ Negative(N*) ___ T.Vaginalis ___ Negative(N*) ___ Positive	_____
		Tech Initials
<input type="checkbox"/> Urine Dip	Leukocytes: ___ Negative(N*) ___ Positive Nitrites: ___ Negative(N*) ___ Positive Blood: ___ Negative(N*) ___ Positive	_____
		Tech Initials
<input type="checkbox"/> Darkfield	___ Negative(No Treponemal organisms seen)(N*) ___ Positive (Treponemal organisms seen)	_____
		Tech Initials
<input type="checkbox"/> Pregnancy Test (hCG)	___ Negative(N*) ___ Positive ___ Invalid (Resubmit fresh sample)	_____
		Tech Initials
SEND OUT TESTS		
Check Test(s) Needed	Results	
<input type="checkbox"/> Amp. Probe Chlamydia	___ Negative(N*) ___ Positive ___ Indeterminate	
<input type="checkbox"/> Amp. Probe Gonorrhea	___ Negative(N*) ___ Positive ___ Indeterminate	
<input type="checkbox"/> Amp. Urine Chlamydia	___ Negative(N*) ___ Positive ___ Indeterminate	
<input type="checkbox"/> Amp. Urine Gonorrhea	___ Negative(N*) ___ Positive ___ Indeterminate	
<input type="checkbox"/> GC Culture Throat	___ Negative(N*) ___ Positive ___ Indeterminate	
<input type="checkbox"/> CT Culture Throat	___ Negative(N*) ___ Positive ___ Indeterminate	
<input type="checkbox"/> GC Culture Rectal	___ Negative(N*) ___ Positive ___ Indeterminate	
<input type="checkbox"/> CT Culture Rectal	___ Negative(N*) ___ Positive ___ Indeterminate	
<input type="checkbox"/> Herpes Culture Direct	___ Negative(N*) ___ Positive ___ Indeterminate	
<input type="checkbox"/> Bacterial Culture	___ Negative(N*) ___ Positive Organism: _____	
<input type="checkbox"/> TPPA Confirmatory	___ Negative(N*) ___ Positive ___ Indeterminate	
<input type="checkbox"/> HIV Confirmatory	___ Negative(N*) ___ Positive ___ Indeterminate	
<input type="checkbox"/>	___ Negative(N*) ___ Positive ___ Indeterminate	
<input type="checkbox"/>	___ Negative(N*) ___ Positive ___ Indeterminate	

(N*) = Normal/Expected Result



**AUSTIN-TRAVIS COUNTY HEALTH & HUMAN
SERVICES DEPARTMENT
COMMUNICABLE DISEASE UNIT
Tuberculosis Elimination Program
15 Waller St., Austin, TX. 78702
(512) 972-5460 (512) 972-5451 FAX**

TUBERCULOSIS CLEARANCE

Name: _____ D.O.B. _____

I, _____, do hereby give my consent to the
(Patient / Parent)

**CITY OF AUSTIN HEALTH AND HUMAN SERVICES/COMMUNICABLE
DISEASE UNIT/TUBERCULOSIS ELIMINATION PROGRAM for the release
of medical information to myself/work/school.**

Patient/Parent Signature: _____ **Date:** _____

TST (Tuberculin Skin Test) Date: _____ **Results:** _____

Tuberculosis Blood Test (i.e. Quantiferon) Date: _____ **Results:** _____

CXR Date: _____ **Results:** _____

Active TB _____

Not active TB (latent TB infection) _____

Cleared: _____

**Treatment Planned
(Medication):** _____

Recommendations for further care: Once a person has had a tuberculin skin test or tuberculosis blood test classified as positive, no further skin/blood tests for TB should be done. Annual chest X-rays for follow-up of the positive skin/blood test are no longer recommended in the absence of symptoms or re-exposure to tuberculosis.

Physician's Signature: _____ **Date:** ____/____/____

If you have any questions related to report, please call 512-972-5460



City of Austin

Founded by Congress, Republic of Texas, 1839

Police Department, P.O. Box 689001, Austin, TX 78768-9001 Telephone 512/974-5000

CITY OF AUSTIN

<https://www.ci.austin.tx.us/devreview/index.jsp>

ADDRESS _____

PERMIT # _____

Building	-	LO	FN	DP	SP
Electrical	-	ES	ER	FE	
Mechanical	-	MR	MV	FM	
Plumbing	-	PR	CP	PG	FL
		SW	PT	FP	
DATE	INSPECTOR				

2 1/8"
↓

Police Department
City of Austin
P.O. BOX 684279
AUSTIN, TEXAS 78768-4279
ALARM UNIT

↓ 3/8"

1 3/8"

2 5/8"





City of Austin Medical Gas Inspection Form

Facility Name and Address:	Installer Name and License #:
-----------------------------------	--------------------------------------

Date:	Permit #:	Inspector:
--------------	------------------	-------------------

Oxygen
 Nitrogen
 Instr. Air
 Nitrous
 WAGD
 CO2
 Vacuum
 Helium
 Medical Air

Category:
 1
 2
 3
 4

Initial Test	Pass or Fail
---------------------	---------------------

Piping Materials Cleaned for Oxygen Service?	
Initial Blow Down	
Nitrogen Purge (NF)	
Inspection of Brazed Joints, Prohibited Joints	
Piping (Size, Protection, Location, Supports, Special Fittings)	
Underground Piping	
Hoses, Flexible Connectors, Head Walls, Appurtenances	
Cross Connections, Prohibited Systems Interconnections	
Labeling and Identification	
Isolation Valves, Zone Valves	
Station Outlets and Inlets	
Alarm Panels	

Secondary Testing	Pass or Fail
--------------------------	---------------------

Initial Pressure Test (Leak Test - Level 3)	
Cross-Connection Test	
Piping Purge Test	
Standing Pressure Test (24 hrs. at 20% above operating pressure) for Positive Pressure Medical Gas Piping	
Standing Pressure Test for Vacuum Systems	
Third Party Verifier Paperwork Provided	

Comments:

Owner / Owner Representative Signature:

Inspector Signature:

Installer Signature:

B i d L I N E I T E M #	FORM NO.	REVIS- ION DATE	TITLE	PAGE SIZE	PAPER COLOR	SPECIAL							EST. 1 YR NEED	MINIMUM ORDER QUANTITY Approx. Quarterly unless otherwise stated	REMARKS
						P A P E R	#	S N A P	N C R	#	2 S I D E	B O O K L E T			
65	CH-TC 500A	Sep-14	EHSD- Food Establishment Inspection Report	8-1/2" x 11"	White	X	2	X	X	1	X			320	Per sample, 25 Forms per pack,
66	CH-TC 500B	Sep-14	EHSD- Food Establishment Inspection Report Page 2	8-1/2" x 11"	White	X	2	X	X	1	X			320	Per sample, 25 Forms per pack,
67	CH-602	Jul-14	EHSD- Order Suspending Permit Form	8-1/2" x 11"	White	X	2	X	X	1				16	Per sample, 25 Forms per pack,
68	CH-602 NCS	Nov-14	EHSD- Notice of Compliance Schedule	8-1/2" x 11"	White	X	2	X	X	1				16	Per sample, 25 Forms per pack,
69	CH-TC 501	Sep-14	EHSD- Food Product Inspection Form	8-1/2" x 11"	White	X	2	X	X	1	X			20	Per sample, 25 Forms per pack,
70	CH-TC 503	Sep-14	EHSD- Mobile Food Vendor Inspection Report Form	8-1/2" x 11"	White	X	2	X	X	1	X			60	Per sample, 25 Forms per pack,
71	CH-TC 502	Sep-14	EHSD- Mobile Food Vendor Permit Inspection Report Form	8-1/2" x 11"	White	X	2	X	X	1	X			60	Per sample, 25 Forms per pack,
72	CH-TC 504	Sep-14	EHSD- Temporary Food Inspection Report Form	8-1/2" x 11"	White	X	2	X	X	1	X			140	Per sample, 25 Forms per pack,

B i d L I N E I T E M #	FORM NO.	REVIS- ION DATE	TITLE	PAGE SIZE	PAPER COLOR	SPECIAL							EST. 1 YR NEED	MINIMUM ORDER QUANTITY Approx. Quarterly unless otherwise stated	REMARKS
						P A P E R	#	S N A P	N C R	#	2 S I D E	B O O K L E T			
73	TC-604 NOV	Mar-08	EHSD- HHSD Notice of Violation Form	8-1/2" x 11"	White	X	2	X	X	1				20	Per sample, 25 Forms per pack,
74	DOG-NOV	Nov-14	EHSD-Dog Enclosure Notice of Violation Form	8-1/2" x 11"	White	X	2	X	X	1				3	Per sample, 25 Forms per pack,
75	FOWL-NOV	Nov-14	EHSD-Fowl Enclosure Notice of Violation Form	8-1/2" x 11"	White	X	2	X	X	1				6	Per sample, 25 Forms per pack,
76	EH-TC 904	Sep-14	EHSD-Pool CO CHOW Inspection Report Form	8-1/2" x 11"	White	X	2	X	X	1	X			10	Per sample, 25 Forms per pack,
77	EH-TC 901	Sep-14	EHSD-Pool Inspection Form	8-1/2" x 11"	White	X	2	X	X	1	X			100	Per sample, 25 Forms per pack,
78	EH-TC 905	Sep-14	EHSD- PWIFF Inspection Report Form	8-1/2" x 11"	White	X	2	X	X	1	X			2	Per sample, 25 Forms per pack,
79	ECHU 701	Jun-11	EHSD- SIPPO/MATTO Inspection Report Form	8-1/2" x 11"	White	X	2	X	X	1				3	Per sample, 25 Forms per pack,
80	EHS RVP	Sep-14	EHSD- Field Inspection Report Form;	8-1/2" x 11"	White	X	2	X	X	1				3	Per sample, 25 Forms per pack,
81	FMC-EHSD	Jan-14	EHSD Food Manager Certificate Form	8-1/2" x 11"	White	X	1			1				200	Per sample, 25 Forms per pack,

B i d L I N E I T E M #	FORM NO.	REVIS- ION DATE	TITLE	PAGE SIZE	SPECIAL										EST. 1 YR NEED	MINIMUM ORDER QUANTITY Approx. Quarterly unless otherwise stated	REMARKS	
					PAPER COLOR	P A P E R 2 0 L B	# P A G E S	S N A P S E T	N C R P A P E R	# I M A G E S	2 S I D E C Y	B O O K L E T	N U M B E R E D					
82	TB400A	Jan-08	ATCHD- Tuberculosis Elimination Division Report of Case and Patient Srvcs Form	8-1/2" x 11"	Yellow	X	1	X			2	X					150	Per sample, 50 Forms per pad, 2 Hole punched at top
83	TB400B	Jan-08	ATCHD- Tuberculosis Elimination Division Report of Case and Patient Srvcs Form	8-1/2" x 11"	Pink	X	1	X			2	X					80	Per sample, 50 Forms per pad, 2 Hole punched at top
84	2200-CD UNIT	Dec-03	ATCHD- Communicable Disease Unit Authorization Form	8-1/2" x 11"	White/ Yellow /Pink	X	3	X	X		3						80	Per sample, 50 Forms per pack
85	2200SSP-CD UNIT	Dec-03	ATCHD- Communicable Disease Unit Autorizacion Para Liberar Informacion Medica Form	8-1/2" x 11"	White/ Yellow /Pink	X	3	X	X		3						50	Per sample, 50 Forms per pack
86	LAB-ORD FORM	Sep-14	ATCHD Communicable Disease Unit Lab Order Form	8-1/2" x 11"	White/ Yellow /Pink	X	3	X	X		3						300	Per sample, 50 Forms per pack

B i d L I N E I T E M #	FORM NO.	REVIS- ION DATE	TITLE	PAGE SIZE	SPECIAL										EST. 1 YR NEED	MINIMUM ORDER QUANTITY Approx. Quarterly unless otherwise stated	REMARKS
					PAPER COLOR	P A P E R	#	S N A P	N C R	#	2 S I D E	B O O K L E T	N U M B E R E D				
87	TBCF	May-09	ATCHD- Communicable Disease Unit TB Clearance Form	8-1/2" x 11"	White/ Yellow /Pink	X	3	X	X	3						50	Per sample, 50 Forms per pack
88	966-30-100-001	Jan-11	COA- Stationery LetterHead	8-1/2" x 11"	White	X	1			1						100	Per sample, 500 sheets per ream
89	HGT-WPDR	Jan-14	Half Green Tag	3-1/2" x 3- 1/4"	Green	Adhesive Label	1			1						600	Per sample, 50 tags per pack
90	ENV-IOE	Jan-14	#10 Interoffice Envelope	4-1/8" x 9- 1/2"	White	X	1			1						20	Per Sample, 500 envelopes per box
91	ENV-#10BUS	Jan-14	#10 Envelope Printed	4-1/8" x 9- 1/2"	White	X	1			1						60	#10 Envelopes packaged 500/box 5 Boxes per Case
92	ENV-#10WBUS	Jan-14	#10 Window Envelope Printed	4-1/8" x 9- 1/2"	White	X	1			1						75	#10 Window Envelopes packaged 500/box 5 Boxes per Case
93	310-48-101-001	Jan-11	Envelope Bid Contract Construction	10 x 13	SU832 MANILA					1						40	Envelope 10x13 packaged 25 per pack
94	310-48-102-001	Jan-11	Envelope Petty Cash	7-1/2 x 10- 1/2	SUB32 MANILA					1						20	Envelope manila packaged 20 per pkg
95	WPDR-CORRN	Jan-14	WPDR- Correction Notice Form	8-1/2 x 11"	White / Pink/ White	X	3	X	X	3						50	Form packaged 50 forms per shrink wrap package
96	WPDR-IRI	Jan-11	WPDR- Investigation/Re- Insection Form	8-1/2 x 11"	White / Pink/ White	X	3	X	X	3						50	Form packaged 50 forms per shrink wrap package

B i d L I N E I T E M #	FORM NO.	REVIS- ION DATE	TITLE	PAGE SIZE	SPECIAL								EST. 1 YR NEED	MINIMUM ORDER QUANTITY Approx. Quarterly unless otherwise stated	REMARKS	
					PAPER COLOR	PAPER #	PER #	PER #	PER #	PER #	PER #	PER #				PER #
97	WPDR-TO	Jan-11	WPDR-Temporary Occupancy Form	8-1/2 x 11"	Yellow/ White	15# & 105#TAG	2	X	X	2					100	Form packaged 50 forms per shrink wrap package
98	WPDR-MGI	Jan-11	WPDR-Medical Gas Initial Inspection Form	8-1/2 x 11"	White/ Canary/ Pink	15#	3	X	X	3					25	Form packaged 50 forms per shrink wrap package
99	WPDR-BKLT	Jan-11	WPDR- Permit Booklet	8-1/2 x 3- 1/2"	White/ Canary/ Pink	X	3	X	X	3		X			50	Five sets of forms per book