



**GARLAND**

HEALTH

1720 Commerce Street  
Garland, TX 75040  
Phone: (972) 205-3460  
Fax: (972) 205-3505  
Email: EnvHealth@GarlandTX.gov

**MPO REGISTRATION FORM**

<b>HEALTH DEPT. OFFICE USE ONLY</b>	
Area:	_____
PT#:	_____
Issue Date:	_____
Exp. Date:	_____
By/Receipt #:	_____

**NAME:** \_\_\_\_\_

**HOME ADDRESS:** \_\_\_\_\_

**HOME TELEPHONE:** \_\_\_\_\_ **WORK TELEPHONE:** \_\_\_\_\_

**E-MAIL ADDRESS:** \_\_\_\_\_

**TX Driver's License or Identification Number** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**DO YOU MANAGE A POOL IN THE CITY OF GARLAND?** YES \_\_\_\_\_ NO \_\_\_\_\_

**PLEASE TELL US WHAT TYPE OF BUSINESS YOU ARE EMPLOYED BY: (check one)**

\_\_\_\_\_ Apartment                      \_\_\_\_\_ Condominium/Loft                      \_\_\_\_\_ Hotel/Motel

\_\_\_\_\_ Health Club                      \_\_\_\_\_ Swimming Pool Service Company                      \_\_\_\_\_ Child Care

\_\_\_\_\_ Other \_\_\_\_\_

**PLACE OF EMPLOYMENT WHERE YOU WILL BE THE CPO:**

**BUSINESS NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**PHONE:** \_\_\_\_\_ **EMAIL:** \_\_\_\_\_

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE:

**MPO SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**(Application must be signed before it can be processed by the City of Garland Health Department)**