

**APPLICATION FOR RECERTIFICATION (BIENNIAL REPORT)
162.001(c) NONPROFIT HEALTH ORGANIZATION
TO CONTRACT WITH OR EMPLOY PHYSICIANS**

Texas Medical Board
P. O. Box 2029
Austin, TX 78768-2029

Texas Medical Board
1801 Congress Ave, Ste 9-200
Austin, TX 78701

(512) 305-7030

I hereby request recertification of _____

(name, address, telephone number of organization)) to contract with or employ physicians licensed by the Texas Medical Board as a non-profit health organization pursuant to the Texas Medical Practice Act, Texas Occupations Code, Section 162.001(c), as amended, and Chapter 177 of the Rules and Regulations of the Texas Medical Board. By my signature at the end of this Application for Recertification and Biennial Report, I certify that I am the _____ (title) of said organization; that I am the officer authorized to act as the chief executive officer; that the following information in support of this Application and Biennial Report has been personally reviewed by me for accuracy, and this information is true and correct. I also certify this nonprofit health organization is in compliance with the requirements for certification and continued certification as required in the Act and the TMB rules, and a current copy of the following documents are attached hereto if not already on file with TMB.

1. Has the Corporation or Hospital District changed its name since the last filing? YES NO (Circle one)

If yes, please indicate the previous name below and submit a copy of the current Certificate of Incorporation.

2. Has the determination by the I.R.S. that the Health Organization is tax exempt under the Internal Revenue Code pursuant to Section 501(c)(3) changed? YES NO Not Applicable/Hospital District (Circle one)

3. Does the organization continue to be organized and operated as a migrant, community, or homeless health center under the authority of and in compliance with 42 U.S.C. Section 254b, 254c, or as a federally qualified health center under 42 U.S.C. Section 1396d(1)(2)(B)? YES NO (Circle one)

_____ (Date) _____ (Signature)

_____ (Typed Name)

_____ (Title)

_____ (Address)

_____ (Address)

_____ (Telephone No.)

STATE OF TEXAS

COUNTY OF _____

BEFORE ME, on this day personally appeared _____, known to me, who, first, being duly sworn, signed the foregoing Application for Certification as a Section 162.001(c) Non-profit Health Organization in my presence indicating that the information contained therein is true and correct.

SIGNED on this the _____ day of _____, 20_____.

Notary Seal

Notary Public, in and for

the State of _____