APPLICATION FOR INITIAL CERTIFICATION:
CERTIFIED 162.001(b) NONPROFIT HEALTH ORGANIZATION

Texas Medical Board
P. O. Box 2029
Austin, Texas 78768-2029
(512) 305-7030

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

On behalf of _____ (*name of organization*), I hereby request certification of _____

_____

(name, address, telephone number of organization) as a non-profit health organization pursuant the Medical Practice Act of Texas, Texas Occupations Code Section 162.001(b) (the "Act"), and Chapter 177 of the Rules of the Texas Medical Board (the "TMB rules"). By my signature at the end of this Application for Original Certification, Initial Identification/Compliance Statement, Initial Document/Compliance Statement, I certify that am the _____ *(title)* of said organization*;* that I am the officer authorized in the bylaws to act as the chief executive officer; that the following information in support of this Application for Original Certification, Initial Identification/Compliance Statement, Initial Document/Compliance Statement has been personally reviewed by me for accuracy, and this information is true and correct.

I. IDENTIFICATION STATEMENT/COMPLIANCE STATEMENT

On behalf of _____(*name of organization*), a Texas non-profit corporation, I hereby make this Initial Identification Statement/Compliance Statement pursuant to the Act, and Chapter 177 of the TMB rules. I hereby certify that (i) I am the _____ _____*(title)* of _____ *(name of organization)*, (ii) I am the officer of _____*(name of organization)* authorized in the bylaws to act as the chief executive officer, (iii) the documentation submitted to your office in support of this statement has been personally reviewed by me for accuracy, and (iv) the below listed names and mailing addresses are current, and I further verify that such information is true and correct and that _____ *(name of organization)* is in compliance with the requirements for certification and continued certification as required by the Act and the TMB rules.

1. NON-PROFIT CORPORATION:

NAME *ADDRESS*

_____

_____

_____

2. MEMBERS:

NAME *ADDRESS*

_____

_____

_____

_____

_____

_____

3. DIRECTORS:

MEDICAL

LICENSE # *NAME* *ADDRESS*

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

4. OFFICERS:

NAME	*OFFICE TITLE*	*ADDRESS*

II. DOCUMENT STATEMENT/DOCUMENT COMPLIANCE STATEMENT

On behalf of _____(*name of organization*, a Texas non-profit corporation, I hereby make this Initial Document Statement/Document Compliance Statement pursuant to the Medical Practice Act of Texas, Texas Occupations Code, Section 162.001 (b) (the "Act"), and Chapter 177 of the Rules of the Texas Medical Board(the "TMB Rules"). I hereby certify that (i) I am the _____*(title)* of _____ *(name of organization);* (ii) I am the officer authorized in the bylaws to act as the chief executive officer; (iii) the documentation submitted to your office in support of this statement has been personally reviewed by me for accuracy; and (iv) **the current certificate of incorporation, articles of incorporation and by-laws of the corporation, including amendments, are attached.** I further verify that such information is true and correct and that _____ _____ *(name of organization)* is in compliance with the requirements for certification as required by the Act and the TMB rules.

III. DIRECTORS' STATEMENTS

Signed statements of each of the current Directors of this Nonprofit Health Organization are attached hereto and are in compliance with the requirements for certification and continued certification as required by Texas Occupations Code, Section 162.001(b),and Chapter 177 of the Rules of the Texas Medical Board.

IV. PRESIDENT'S OR CHIEF EXECUTIVE OFFICER'S VERIFICATION

_____ (Date) _____ (Signature)

_____ (Printed Name)

_____ (Title)

_____ (Address)

_____ (Address)

_____ (Telephone No.)

_____(Email Address)

STATE OF _____ §
§
COUNTY OF _____ §

BEFORE ME, on this day personally appeared _____, known to me, who, first, being duly sworn, signed the foregoing Application for Certification, Initial Identification Compliance Statement, and Initial Document/Compliance Statement on Non-profit Certification in my presence indicating that the information contained therein is true and correct.

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

_____

Notary Seal NOTARY PUBLIC

DIRECTOR'S STATEMENT

STATEMENT OF _____

THE STATE OF TEXAS §
§
COUNTY OF _____ §

_____, hereby states to the Texas Medical Board (the "TMB") with full knowledge that the TMB will rely upon these statements in acting upon an application for certification or for purposes of continued certification of _____ under Chapter 177 of the TMB'srules, as follows:

1. My name is _____. I am licensed under the Medical Practice Act, Texas Occupations Code, Subtitle B, (the "Act")to practice medicine in the State of Texas. My medical license number is _____.

2. I am on the Board of Directors of _____, a non-profit corporation incorporated in Texas (the "Corporation"). Pursuant to the Articles of Incorporation and Bylaws of the Corporation, the directors of the Corporation and their successors in office are required to be licensed by the TMB and "actively engaged in the practice of medicine". In making this statement, I have reviewed the Articles of Incorporation and the Bylaws of the Corporation.

3. I am "actively engaged in the practice of medicine" defined as follows: engaged in diagnosing, treating or offering to treat any mental or physical disease or disorder or any physical deformity or injury or performing such actions with respect to individual patients for compensation and shall include clinical medical research, the practice of clinical investigative medicine, the supervision and training of medical students or residents in a teaching facility or program approved by the Liaison Committee on Medical Education of the American Medical Association, the American Osteopathic Association or the Accreditation Council for Graduate Medical Education, and professional managerial, administrative, or supervisory activities related to the practice of medicine or the delivery of health care services. The term "full-time basis," for purposes of this section, shall mean at least 20 hours per week for 40 weeks duration during a given year.

4. In serving as a director of the Corporation, I shall comply with all relevant provisions of the Actand the TMB rules.

5. In serving as a director of the corporation, I shall exercise best efforts to cause the Corporation to comply with all relevant provisions of the Act and the TMB rules.

6. I shall exercise independent judgment as a director in all matters and, specifically, matters relating to credentialing, quality assurance, utilization review, peer review, and the practice of medicine.

7. I shall immediately report to the TMB any act or event that I reasonably and in good faith believe constitutes a violation or attempted violation of the Actor the TMB rules.

8. Any financial relationship that I have with (i) the members of the Corporation, or (ii) the other directors of the Corporation, any Supplier (as defined below), or any affiliate with any member, other director, or Supplier, has been disclosed to the members of the Corporation and the Board of Directors of the Corporation. All such financial relationships are described below, and I am disclosing such financial relationship(s) to the TMB by this statement. The term "Supplier" as used in this letter means (i) a physician retained to provide medical services to or on behalf of the Corporation, or (ii) any other person providing or anticipated to provide services or supplies to or on behalf of the Corporation in excess of $10,000 during a twelve-month period.

FINANCIAL RELATIONSHIPS

Indicate financial relationships held with suppliers, the non-profit health organization, members, or other directors - DO NOT LEAVE BLANK

Check all that apply:

☐ Salary	☐ Stipend	☐ Per Diem
☐ Commission	☐ Royalties	☐ Stock Options
☐ Benefits Package	☐ Office Space	☐ Other
	☐ No Financial Relationships	

I hereby affirm that the information included on this Director's Statement is true and correct in every detail.

_____ _____

(Signature of Physician) (Date)