APPLICATION FOR INITIAL CERTIFICATION:
162.001(c) NONPROFIT HEALTH ORGANIZATION
TO CONTRACT WITH OR EMPLOY PHYSICIANS

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) to contract with or employ physicians licensed by the Texas Medical Board as (check one):

_____ 1. Texas Medical Practice Act, Texas Occupations Code Annotated, Section 162.001(c)

A non-profit corporation pursuant to the Texas Medical Practice Act, Texas Occupations Code Annotated, Section 162.001(c), as amended, and Chapter 177 of the Rules of the Texas Medical Board, organized and operated as:

- a community health center under the authority of and in compliance with 42 U.S.C. Section 254b or 254c; or,
- a federally qualified health center under 42 U.S.C. Section 1396d (1)(2)(B).

_____ 2. Texas Medical Practice Act, Texas Occupations Code Annotated, Section 162.001(c-4)

A hospital district created in a county with a population of more than 800,000 that was not included in the boundaries of a hospital district before September 1, 2003, that is recognized by a federal agency as a public entity eligible to receive a grant related to:

- a community health center under the authority of and in compliance with 42 U.S.C. Section 254b or 254c; or,
- a federally qualified health center under 42 U.S.C. Section 1396d (1)(2)(B).

I hereby certify that I am the chief executive officer of _____ _____ *(name of organization)*, and that the attached documentation in support of this application has been personally reviewed by me for accuracy, and I further certify that this attached information is true and correct. This organization is eligible for approval and certification due to its status as indicated above.

Attached are true and correct copies of current documents verifying the above information.

_____(Signature) _____ (Date)

_____(Printed Name) _____ (Phone #)

_____(Title)

_____

(Address)

_____

(Address)

_____

(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 Approval and Certification To Contract With or Employ physicians As a Certified 162.001(c) 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