Pain Management Clinic Registration

Mailing Address
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MC-240
Austin, TX 78768-2029

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Tower 3, Suite 610
Austin, TX 78701

Phone (512) 305-7030 **Fax (888) 512-2581**
General Information E-mail: registrations@tmb.state.tx.us
Pain Management Clinic Web Page:
https://www.tmb.state.tx.us/page/renewal-pain-mgt-clinic-pegistration

Definition: A pain management clinic is defined in statute and rule as a publicly or privately-owned facility for which a majority of patients are issued, on a monthly basis, a prescription for opioids, benzodiazepines, barbiturates, or carisoprodol, but not including suboxone.

A pain management clinic may not operate in Texas without obtaining a certificate from the Texas Medical Board (TMB). Use this form to register for pain management clinic certification and re-certification.

Instructions

The following documents must be submitted with your completed registration:

- **Proof of clinic ownership** - Documents that may demonstrate ownership include:
  For FEIN (Federal Employer Identification Numbers) tax IDs issued by the IRS used on registration:
  - IRS issued Form SS-4 ;
  - IRS issued form LTR 147c;
  - IRS records for the clinic,
  - certificates of ownership for unincorporated entities issued by a state county. If there are differences in names that can be explained by DBA records with the county, those records should also be submitted.

  For State Issued Tax IDs (including State Franchise Tax IDs) tax IDs issued by the SOS used on registration:
  - filings with the Secretary of State,
  - state franchise tax documents,

  For DBA or Assumed Names the Clinic operates under other than the name listed on the IRS or SOS
  - Certificates of ownership for Assumed names or DBAs issued by a state county.
  - Assumed name certificates filed with the SOS

  The TMB may require additional documentation if proof of ownership documents submitted are inconclusive for purposes of determining ownership for each owner of the clinic.

- **NPDB/HPDB –** You, the clinic's proposed medical director if different, and all physician owners must contact the National Practitioner Data Bank (NPDB)/Healthcare Integrity and Protection Databank (HIPDB) at http://www.npdb-hipdb.hrsa.gov/ and perform a self-query. Send in all the responses and indicate the queries are for your clinic's pain management clinic certification.

- **Statement of Active Practice –** Please provide a statement of evidence that you have practiced medicine full-time (at least 20 hours per week for 40 weeks) for one of the two years preceding the date of application (per Board rule 195.2(b)(3)).

Certificates, once issued, are not transferable or assignable. Only the primary physician owner is required to register with the board if there is more than one physician owner of the clinic. Each clinic requires a separate certificate.

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Normal processing time is 60 days from the date of receipt, by TMB, of the form. Check the web site https://www.tmb.state.tx.us/page/look-up-a-license under 'Other Healthcare professionals' to confirm registration.

Ownership and Operation

A pain management clinic may not operate in Texas unless the clinic is owned and operated by a medical director who:

- is a physician who practices in Texas;
- has an active, unrestricted medical license;
- holds a certificate of registration for that pain management clinic.

All owners must be Texas licensed physicians.

In addition, the owner/operator of a pain management clinic, an employee of the clinic, or a person with whom a clinic contracts for services **may not**:

- have been denied, by any jurisdiction, a license issued by the Drug Enforcement Agency or a state public safety agency under which the person may prescribe, dispense, administer, supply, or sell a controlled substance;
- have held a license issued by the Drug Enforcement Agency or a state public safety agency in any jurisdiction, under which the person may prescribe, dispense, administer, supply, or sell a controlled substance, that has been restricted; or
- have been subject to disciplinary action by any licensing entity for conduct that was a result of inappropriately prescribing, dispensing, administering, supplying, or selling a controlled substance

A pain management clinic **may not** be owned wholly or partly by a person who has been convicted of, pled nolo contendere to, or received deferred adjudication for:

- an offense that constitutes a felony; or
- an offense that constitutes a misdemeanor, the facts of which relate to the distribution of illegal prescription drugs or a controlled substance as defined by Texas Occupations Code Annotated §551.003(11)

The medical director of a pain management clinic must operate the clinic in compliance with Drug Prevention and Control Act, 21 U.S.C.A. 801 et.seq. and the Texas Controlled Substances Act, Chapter 481 of the Texas Health and Safety Code, relating to the prescribing and dispensing of controlled substances.

The medical director of a pain management clinic must, on an annual basis, ensure that all personnel:

- are properly licensed(if applicable);
- are trained including, but not limited to, 10 hours of continuing medical education related to pain management; and
- are qualified for employment.

Fees and Expiration dates

At this time, there is no charge to register a pain management clinic.

Certificates are valid for two years from date of issuance. Certificates must be timely renewed.

Certificates not renewed on or before the expiration date are considered delinquent. <u>The clinic may not continue to operate after the permit expires.</u>

There is a 180-day grace period after the expiration date in which the certificate may still be renewed. After the 180-day grace period, the certificate is automatically cancelled and the owner or operator of the clinic must reapply for original certification if a certificate is needed.

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PAIN MANAGEMENT CLINIC INFORMATION (PLEASE PRINT)

Clinic Name

Address (PO Box not allowed)

City | **State** | **Zip Code**

Phone Number | **Fax Number**

State Franchise Tax ID Number | **Federal Employer Identification Number (EIN)**

Check if clinic is your primary practice site. ☐

Agency use only:

TMB Certification Number (if applicable) | **Clinic ID #**

PRIMARY PHYSICIAN OWNER, CO-OWNER INFORMATION (PLEASE PRINT)

Last Name | **First Name** | **Suffix** MD/DO

Home Address (PO Box not allowed)

City | **State** | **Zip Code**

Phone Number | **Email Address** | **Fax Number** | **TX License #**

DEA Controlled Substance Number | **DEA Expiration date** | **Percent of Ownership**

☐ **Check if Medical Director is the same as Primary Physician Owner**

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PLEASE RESPOND TO ALL OF THE FOLLOWING ELIGIBILITY QUESTIONS		
Do you currently hold an active, unrestricted medical license in Texas? If the answer to this question is "no," you are not currently eligible to own and operate a pain management clinic.	**Yes**	**No**
Are all owners of the pain management clinic physicians? If the answer to this question is "no," the clinic is not eligible for certification as a pain management clinic.	**Yes**	**No**
Have you practiced clinical medicine at least 20 hours a week for at least 40 weeks within the last two years? If the answer to this question is "yes" please provide documentation to prove the medical director meets active practice requirements. If the answer to this question is "no," the clinic is not eligible for certification as a pain management clinic.	**Yes**	**No**
If you are not the clinic's proposed medical director, has the medical director practiced clinical medicine at least 20 hours a week for at least 40 weeks within the last two years? If the answer to this question is "yes" please provide documentation to prove the medical director meets active practice requirements. If the answer to this question is "no," the clinic is not eligible for certification as a pain management clinic.	**Yes**	**No**
Have you, any co-owner, current employee or person with whom you contract services ever:		
been denied, by any jurisdiction, a license issued by the Drug Enforcement Agency or a state public safety agency under which the person may prescribe, dispense, administer, supply or sell a controlled substance?	**Yes**	**No**
held a license issued by the Drug Enforcement Agency or a state public safety agency in any jurisdiction, under which the person may prescribe, dispense, administer, supply, or sell a controlled substance, that has been restricted?	**Yes**	**No**
been subject to disciplinary action by any licensing entity for conduct that was a result of inappropriately prescribing, dispensing, administering, supplying, or selling a controlled substance?	**Yes**	**No**
If the answer to any of the above questions is "yes," you are not currently eligible to own and operate a pain management clinic.		
Have you, or any co-owner, ever been convicted of, pled nolo contendere to, or received deferred adjudication for:		
an offense that constitutes a felony?	**Yes**	**No**
an offense that constitutes a misdemeanor, the facts of which relate to the distribution of illegal prescription drugs or a controlled substance?	**Yes**	**No**
If the answer to any of the above questions is "yes", you are not currently eligible to own and operate a pain management clinic.		

Pain Management Clinic Registration

List and provide the information requested for the medical director (if different from the primary owner), and ALL owners besides the primary physician owner. Attach additional pages as needed.

Medical Director Name (printed): ______________________

Address ______________________
____
____

License Number ________

Percent of Ownership ________

DEA CSR ______________

Phone ______________________
Fax ______________________
E-mail ______________________

Alternate Physician Owner Name (printed): ______________________

Address ______________________
____
____

License Number ________

Percent of Ownership ________

DEA CSR ______________

Phone ______________________
Fax ______________________
E-mail ______________________

Alternate Physician Owner Name (printed): ______________________

Address ______________________
____
____

License Number ________

Percent of Ownership ________

DEA CSR ______________

Phone ______________________
Fax ______________________
E-mail ______________________

Alternate Physician Owner Name (printed): ______________________

Address ______________________
____
____

License Number ________

Percent of Ownership ________

DEA CSR ______________

Phone ______________________
Fax ______________________
E-mail ______________________

Alternate Physician Owner Name (printed): ______________________

Address ______________________
____
____

License Number ________

Percent of Ownership ________

DEA CSR ______________

Phone ______________________
Fax ______________________
E-mail ______________________

Pain Management Clinic Registration

HOURS OF OPERATION, MEDICAL DIRECTOR ON-SITE HOURS

List the hours of operations of the clinic and hours the Medical Director will be on site. If the same schedule is followed weekly, use only Week 1. For every other week schedules, use Weeks 1-2. For other schedules, use Weeks 1-4.

	Sun	Mon	Tue	Wed	Thu	Fri	Sat
Week 1							
Clinic Hours of Operation (e.g., 8-5)							
Medical Director Hours On Site (e.g., 9-12)							
Week 2							
Clinic Hours of Operation (e.g., 8-5)							
Medical Director Hours On Site (e.g., 9-12)							
Week 3							
Clinic Hours of Operation (e.g., 8-5)							
Medical Director Hours On Site (e.g., 9-12)							
Week 4							
Clinic Hours of Operation (e.g., 8-5)							
Primary Physician Owner Hours On Site (e.g., 9-12)							
Week 5							
Clinic Hours of Operation (e.g., 8-5)							
Medical Director Hours On Site (e.g., 9-12)							

I certify that the information that I have provided on this application is correct. I understand that it is a violation of the Medical Practice Act, Tex. Occ. Code Ann. §164.051(a)(1) and §164.052(a)(2) and the Tex. Pen. Code Ann. §37.10 to submit a false or misleading statement to a governmental agency. I acknowledge that the Texas Medical Board (TMB) is not authorized to issue a pain management certification if I do not provide all requested information. I certify that I am the person named in this document, and all statements I have made are true.

_____ _____

Physician Primary Owner Signature **Date**

I certify that all personnel are qualified for employment and have met CME requirements of 10 hours related to pain management.

_____ _____

Physician Medical Director Signature **Date**

Note – Please refer to instructions for additional items you must submit with this registration.