Abortion Facility License Renewal Addendum

Name of Facility: ____

License Number: __________________

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1. Administrator:

Name: ____

Email: ____

Phone: ____

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2. Personnel -

Submit names, Texas Provider Identification numbers (if Medicaid-enrolled), National Provider Identification numbers, and license numbers and expiration dates of **all licensed professionals** who provide services at the abortion facility. *(Use the attached sheet if necessary.)*

Name: ____

Texas Provider ID #: ______________________________

National Provider ID #: ____________________________

License #: _____________________________________

Expiration Date: _________________________________

Name: ____

Texas Provider ID #: ______________________________

National Provider ID #: ____________________________

License #: _____________________________________

Expiration Date: _________________________________

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3. Submit a copy of the organizational structure of the staffing for the facility.

Personnel Continued:

Name: ____
Texas Provider ID #: ____
National Provider ID #: _____________________________________
License #: ____
Expiration Date: ____

Name: ____
Texas Provider ID #: ____
National Provider ID #: _____________________________________
License #: ____
Expiration Date: ____

Name: ____
Texas Provider ID #: ____
National Provider ID #: _____________________________________
License #: ____
Expiration Date: ____

Name: ____
Texas Provider ID #: ____
National Provider ID #: _____________________________________
License #: ____
Expiration Date: ____

Name: ____
Texas Provider ID #: ____
National Provider ID #: _____________________________________
License #: ____
Expiration Date: ____