TEXAS Health and Human Services

Freestanding Emergency Medical Care Facility Renewal Application

Name of Facility: _____

License Number: _____

Type of Ownership:

- ☐ City
- ☐ Corporation
- ☐ County
- ☐ Hospital
- ☐ Other: _____
- ☐ Hospital District/Authority
- ☐ Limited Liability Company (LLC)
- ☐ Limited Liability Partnership (LLP)
- ☐ Limited Partnership (LP)
- ☐ LTD
- ☐ Partnership
- ☐ Sole Owner/Proprietorship
- ☐ State

Status: ☐ Profit ☐ Non-Profit

---

1. ACCREDITATION:

(Check the appropriate category)
Attach a copy of the most recent letter or certificate of accreditation.

☐ Joint Commission (JC)

☐ Other Accreditation Agency: _____

☐ Not accredited

---

2. EMERGENCY TREATMENT STATIONS:

Provide the total number of Emergency Treatment Stations: _____

---

3. FIRE SAFETY SURVEYS:

Annual fire safety inspections are required for continued licensure status. Please include a copy of a fire inspection report conducted within the last 12 months and one from the year prior indicating approval by the ***local*** fire authority.

4. MEDICAL STAFF

a. Medical Chief of Staff:

_____ _____ _____
Name License # Expiration Date

b. Director of Nurses:

_____ _____ _____
Name License # Expiration Date

5. SAFE-READY FACILITY

Is your facility a SAFE-ready facility? ☐ Yes ☐ No

"SAFE-ready facility" means a health care facility designated as a Sexual Assault Forensic Exam-ready facility under TX Health and Safety Code Section 323.0015. A SAFE-ready facility employs or contracts with a sexual assault forensic examiner or uses a telemedicine system of sexual assault forensic examiners to provide consultation to a licensed nurse or physician when conducting a sexual assault forensic medical examination.

6. SIGNATURE AND ATTESTATION:

The administrator attests that the owner is capable of meeting the requirements of 25 Texas Administrative Code, Chapter 131, Freestanding Emergency Medical Care Facilities. The administrator attests that all information contained in this application is true and correct. The administrator attests that all copies submitted with the application are original copies or copies of the original documents. The administrator attests that at least one physician licensed in the State of Texas and at least one registered nurse licensed in the State of Texas are on site during all hours of operation.

_____ _____
Administrator's Name **(Please Print)** Title

_____ _____
Administrator's Signature Date Signed

_____ _____
Administrator's Email Address Administrator's Telephone Number

7. CONTACT PERSON:

_____ _____
Name of the person completing this application Title

_____ _____
Telephone Number Email Address

PHYSICIAN OWNERSHIP **N / A** ☐

Texas Administrative Code, Chapter 131.25(d)(4) requires the facility to submit the names, license numbers, and expiration dates of those licenses of any physician licensed by the Texas Medical Board who has a financial interest in the facility or in any entity that has an ownership interest in the facility.

Name: ____
Texas Medical Board License Number: __________________________
Expiration Date of License: __________________________________

Name: ____
Texas Medical Board License Number: __________________________
Expiration Date of License: __________________________________

Name: ____
Texas Medical Board License Number: __________________________
Expiration Date of License: __________________________________

Name: ____
Texas Medical Board License Number: __________________________
Expiration Date of License: __________________________________

Name: ____
Texas Medical Board License Number: __________________________
Expiration Date of License: __________________________________

Name: ____
Texas Medical Board License Number: __________________________
Expiration Date of License: __________________________________

Name: ____
Texas Medical Board License Number: __________________________
Expiration Date of License: __________________________________

Name: ____
Texas Medical Board License Number: __________________________
Expiration Date of License: __________________________________

Name: ____
Texas Medical Board License Number: __________________________
Expiration Date of License: __________________________________

Name: ____
Texas Medical Board License Number: __________________________
Expiration Date of License: __________________________________

Name: ____
Texas Medical Board License Number: __________________________
Expiration Date of License: __________________________________