



Freestanding Emergency Medical Care Facility (FEC) License Renewal Application

Name of FEC: _____

License Number: _____

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

Status: Profit Non-Profit

1. ACCREDITATION

Please check the category that applies. Attach a copy of the most recent accreditation letter or certificate.

Joint Commission (JC)
 Other _____
 Not accredited

2. EMERGENCY TREATMENT STATIONS:

Provide the total number of Emergency Treatment Stations: _____

3. MEDICAL STAFF

a. Medical Chief of Staff:

_____	_____	_____
Name	License #	Expiration Date

b. Director of Nursing:

_____	_____	_____
Name	License #	Expiration Date

4. FIRE SAFETY SURVEYS:

Two approved Fire Safety Survey Report forms must be submitted. Annual fire safety inspections are required for continued licensure status. Include a copy of a fire inspection report conducted within the last 12 months & a second report conducted within the last 13 to 24 months indicating approval by the local fire authority.

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BUDGET: ZZ104
FUND: 001

5. 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

6. CONTACT PERSON:

Name of the person completing this application

Title

Telephone Number

Email Address

Mailing address for applications with fees: Department of State Health Services, Facility Licensing Group, Mail Code 2003, PO Box 149347, Austin, TX 78714-9347

Overnight mailing address for applications with fees: Department of State Health Services, Facility Licensing Group, Mail Code 2003, 1100 West 49th Street, Austin, TX 78756

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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: _____

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Name: _____

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Name: _____

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