Texas Board of Orthotics & Prosthetics
Facility Accreditation Application Instructions

(512) 834-4520
Fax: (512) 834-6677
E-mail: op@tdh.state.tx.us

Please read these instructions and the enclosed laws and rules governing the accreditation of orthotic and/or prosthetic facilities in Texas before completing the application.

- Facility accreditation is required where orthotics and/or prosthetics are conducted. Facility accreditation is not required at facilities where only fabrication is done.

Notify the Board office, in writing, immediately of any changes to a response given in the application. Failure to do so could result in the denial or revocation of accreditation. Examples: change of address, business type, type of facility, or an incorrect answer to a question.

An application is not complete until all required documentation / information and fees are received.

Fees may be paid by personal check, business check, money order, or cashier's check made payable to the Texas Board of Orthotics & Prosthetics. Do not send cash.

Application Information:

1. Facility Name. Facility's full legal name. If doing business under another name, please explain on a separate sheet of paper.

2. Mailing Address. Address where mail for facility is sent.

3. Physical Address. Actual physical location of the facility. Include street number and name, suite number, city, state, and zip code. If same as Mailing Address, enter "same."

4. Business Telephone. Include area code.

5. Fax Number. Include area code.

6. E-mail Address. If one does not exist, enter "none."

Application Information Continued:

7a. Check this item if business is a corporation. Use the space provided to list the name(s), address(es), social security number(s), and percentages of ownership of all persons who directly or indirectly own or control 5% or more of the outstanding shares of stock in the facility. Also, list the name(s) and address(es) of all directors. Attach separate sheets of paper if more space is needed. See §821.29(c)(1)(D) of the rules.

7b. Check this item if business is a sole proprietorship or partnership. Use the space provided to list the name(s), current mailing address(es), telephone number(s), and social security number(s) for the sole proprietor or all partners. Attach separate sheets of paper is more space is needed. See §821.29(c)(1)(E) of the rules.

7c. Check this item if business is not a corporation, sole proprietorship or partnership. Use the space provided to list the name(s), current mailing address(es), telephone number(s), and social security number(s) of all owners. Attach a separate sheet of paper describing the type of organization. See §821.29(c)(1)(F) of the rules.

8. Enter the total square footage of the facility. See §821.29(c)(1)(G) of the rules.

9a. Type of Facility. Check the appropriate item. Check only one item.

9b. Enter the Date of the first patient treatment date. See §821.29(e)(2) of the rules.

9c. Indicate whether facility was previously accredited under another business name.

10. Employees. List the name and license / certificate number of all licensees who work in the facility. Attach additional sheets if necessary. If the employees have not received license / certificate numbers when the facility accreditation application is submitted, list only the names. See §821.29(c)(1)(I) of the rules.

11. Safety Manager. List the name(s) and license or registration number(s) of the individual(s) that is/are designated as the facility safety manager(s). See §829.29(c)(1)(I).

12a. Practitioner-In-Charge. If you have an orthotic facility, you need an orthotist-in-charge who is ON-SITE to provide clinical direction and supervise the provision of services at the facility. If you have a prosthetic facility, you need a prosthetist-in-charge. If you have a prosthetic / orthotic facility, you need either a prosthetist / orthotist-in-charge, or both a prosthetist-in-charge and orthotist-in-charge. Check the appropriate box(es) and fill the name(s), license number(s), signature(s), and date(s). If the employees have not received license / certificate numbers when the facility accreditation application is submitted, list only the names. See §821.29(c)(1)(H) of the rules.

12b. List any additional facilities at which the designated Practitioner-In-Charge works.

13. Attestations. The practitioner(s)-in-charge must complete this section. Each item, from A to JJ, must be initialed by the practitioner(s)-in-charge. Do not leave any items blank.

14. Affidavit. The application must be signed and dated by the practitioner(s)-in-charge and notarized by a Notary Public. Two signature lines are available for the practitioner-in-charge, if needed.

15. Fees. The fee and payment coupon on page 5 must be enclosed with the application. The fee for a prosthetic or orthotic facility accreditation is $400.00. The fee for a prosthetic / orthotic facility accreditation is $500.00.

Schedule of Fees:

Prosthetic or orthotic facility accreditation ……$405
Prosthetic and orthotic facility accreditation……$505
Accreditation duplicate or replacement……$25
Returned Check……$25

NOTE

Due to mail processing procedures at the Texas Department of State Health Services, mail is not delivered directly to this office. Pay careful attention to the addresses listed below. Failure to send mail to the proper address can cause delays.

- **All correspondence containing fees <u>must</u> be sent to:**

  Texas Board of Orthotics & Prosthetics
  PO Box 12197
  Capitol Station
  Austin, TX 78711-2197

- **General correspondence <u>not</u> containing fees should be sent to:**

  Texas Board of Orthotics & Prosthetics
  P.O. Box 149347, Mail Code 1982
  Austin, Texas 78714-9347

- **Complaints should be sent to:**

  Texas Board of Orthotics & Prosthetics
  Complaints Division
  PO Box 141369
  Austin, TX 78714-1369

▼ CUT COUPON AND RETURN WITH YOUR APPLICATION ▼

PAYMENT COUPON

Budget ZZ132
Fund #106

Facility Name: _____

Amount Enclosed: _____

Texas Board of Orthotics & Prosthetics
PO Box 12197
Capitol Station
Austin, TX 78711-2197

Facility Accreditation Application
Texas Board of Orthotics and Prosthetics
(512) 834-4520

Budget ZZ132
Fund #106

1. FACILITY NAME	
2. MAILING ADDRESS	
3. PHYSICAL ADDRESS	
☐ Check here if same as mailing	
4. BUSINESS TELEPHONE	( )
5. FAX NUMBER	( )
6. E-MAIL ADDRESS	

BUSINESS TYPE (check one only)

____ **7a. Corporation.** List the name(s), address(es), social security number(s), and percentage of ownership of all persons who directly or indirectly own or control 5% or more of the outstanding shares of stock in the facility below. Also, list the name(s) and address(es) of all directors. Attach additional sheets if necessary. . 821.29(c)(1)(D)

____ **7b. Sole Proprietor or Partners.** List the name(s), address(es), phone number(s), and social security number(s) for the sole proprietor or all partners below. Attach additional sheets if necessary. . 821.29(c)(1)(E)

____ **7c. Other.** List the name(s), address(es), phone number(s), and social security number(s) of all owners. Attach a separate sheet that includes a description of the type of organization. . 821.29(c)(1)(F)

NAME	ADDRESS	PHONE NUMBER	PERCENTAGE OF OWNERSHIP	SOCIAL SECURITY NUMBER

GENERAL INFORMATION

8. Total square footage of the facility. . 821.29(c)(1)(G) _____

9a. Type of Facility. (check one) ____**Orthotic** ____**Prosthetic** ____**Orthotic/Prosthetic**

9b. Date first patient was treated. . 821.29(e)(2) _____

9c. Has this facility ever been accredited under another business name? If so, please list name:

_____ §821.29(e)(10)

10. Employees. List the names and license numbers of all individuals, licensed under the Act, who practice in this facility. Add additional sheets if necessary. . 821.29(c)(1)(I)

NAME	LICENSE NUMBER	NAME	LICENSE NUMBER

11. Safety Manager. List the name(s) and license or registration number(s) of the individual(s) that is/are designated as the facility safety manager(s).

NAME	LICENSE NUMBER	NAME	LICENSE NUMBER

12a. Practitioner In Charge. List the name(s) and license number(s) of the prosthetist and/or orthotist who is ON-SITE and in charge. See §821.29(c)(1)(H)

____**Orthotist in Charge**

Name: _____ **License Number:** _____

Signature: _____ **Date Signed:** _____

____**Prosthetist in Charge**

Name: _____ **License Number:** _____

Signature: _____ **Date Signed:** _____

12a. Practitioner In Charge Continued.

____Prosthetist/Orthotist in Charge

Name: _____ License Number: _____

Signature: _____ Date Signed: _____

12b. List all other facilities at which the above named Practitioner(s) is/are employed. (Attach additional pages if Necessary.) Attach a work schedule showing the day/time that the practitioner is at each facility.

PRACTIONER NAME	FACILITY NAME	ADDRESS	Designated as the Practioner-in-charge?	
			Yes	No
			Yes	No
			Yes	No
			Yes	No

13. Attestations – Compliance with Requirements for Accredited Facilities.

In accordance with the rules adopted by the Texas Board of Orthotics & Prosthetics, §821.29, Accreditation of Prosthetic and Orthotic Facilities, the prosthetist and/or orthotist in charge (POIC) shall agree to comply with the requirements for facility accreditation, which include, but are not limited to the following items. The POIC must signify agreement to comply **by initialing the space provided in front of each item. Do not leave any items blank. Initialing the items below signifies agreement to comply with the facility requirements of the Board's rules concerning §821.29 Accreditation of Prosthetic and Orthotic Facilities that can be verified by site inspection.** The applicable Board rule is cited after each item.

If accreditation is granted, I/we _____ agree that:
(Type or print name of POIC)

A. Administration: (Each entry must be initialed by all POIC)

_____ 1. The entire facility building and property meet applicable federal, state, and local laws, codes, and other applicable requirements. §821.29(e)(1).

_____ 2. The accreditation certificate will be displayed in a prominent location in the facility where it is available for inspection by the public. The accreditation certificate issued by the Board is the property of the Board and must be surrendered on demand. §821.29(e)(3).

_____ 3. The facility is subject to random inspection to verify compliance with the Act and rules at anytime, by authorized Board personnel. The Board may also conduct inspections if the Board receives a complaint regarding the facility. §821.29(e)(4).

_____ 4. The facility is under the clinical on-site direction of a prosthetist, orthotist, or prosthetist / orthotist licensed by the Board in the discipline I which the facility sought accreditation, and that that person supervises the provision of prosthetics and/or orthotics in accordance with the Act an rules and is the person in charge. §821.29(e)(5).

_____ 5. The facility shall report all changes to the Board regarding the designation or assignment of the on-site prosthetist, orthotist, or prosthetist / orthotist who is clinically directing the facility within 30 days after the change. §821.29(e)(8).

_____ 6. The facility is required to comply with the Act and rules of the Board. §821.29(e)(6).

_____ 7. The facility shall prominently display a sign in letters at least one inch in height, containing the name, mailing address, and telephone number of the Board, a statement informing consumers that complaints against licensees of the facility may be directed to the Board, and the toll-free telephone number for presenting complaints to the Board about a person or the facility. §821.29(e)(7).

_____ 8. The facility accreditation shall not be transferred or sold to another facility or owner, nor transferred to a different location without written approval of the executive director. §821.29(e)(10).
_____ 9. The facility agrees to comply with the change in ownership requirements. §821.29(f).
_____10. The facility must renew its accreditation every two years. The Board shall not renew the accreditation of a facility that is violating or has violated the Act or these rules until the facility has corrected the violation(s) to the satisfaction of the Board. §821.29 (h)(2) and (4).
_____11. The renewal shall be affixed to or displayed with the original accreditation and is the property of the Board. §821.29(h)(6).
_____12. Disciplinary action against a facility for violation of the Act or rules may include a reprimand, revocation, or suspension of the accreditation, probation, imposition of an administrative penalty against the facility or other appropriate disciplinary action. §821.29(k)(1).
_____13. A revocation or suspension of an accreditation affects all facilities accredited under one primary accreditation. §821.29(k)(3).

B. Facility Cleanliness: <u>(Each entry must be initialed by all POIC)</u>

_____ 1. The facility shall be constructed and maintained appropriately to provide safe and sanitary conditions for the protection of the patient and the personnel providing prosthetic and orthotic care. §821.29(l).
_____ 2. Patient examination and treatment rooms shall be cleaned after each patient is seen. §821.29 (l)(1).
_____ 3. Hand soap, hand towels or hand dryers must be available at the sinks used by employees and patients. §821.29(l)(2).
_____ 4. Exam tables must have disposable covers or disinfected surfaces. §821.29(l)(3).
_____ 5. Appropriate gloves and disinfectants for disease control must be available in examination rooms and treatment areas. §821.29(l)(4).
_____ 6. Patient waiting areas must be separate from the other areas. §821.29(m)(1).
_____ 7. Chairs with armrests must be provided in waiting rooms. §821.29(m)(2).
_____ 8. A telephone must be made available for patient use. §821.29(m)(3).
_____ 9. Rooms in which patients are seen must maintain privacy and have permanent, floor-to-ceiling walls or dividers and rigid doors. Windows must assure privacy. §821.29(n)(1).
_____10. At least one set of parallel bars and a mirror for patient ambulation trials must be provided in each facility. §821.29(n)(2).

C. Safety: <u>(Each entry must be initialed by all POIC)</u>

_____ 1. Chairs with armrests must be provided in examination / treatment rooms. §821.29(n)(3).
_____ 2. Safety equipment (safety glasses / goggles and dust masks) must be available to persons working in the facility. §821.29(o)(1).
_____ 3. Proper machine use and training must be provided. §821.29(o)(2).
_____ 4. Safety guards on machines must always be in place. §821.29(o)(3).
_____ 5. Lab / fabrication areas must be separated from other areas by walls and/or doors and have adequate ventilation and lighting. §821.29(o)(4).
_____ 6. If smoking is permitted, policies and procedures are in place to control smoking materials. §821.29(o)(5).
_____ 7. A minimum of one licensee or registrant must be assigned to each facility to act as safety manager. The safety manger is responsible for developing, implementing, monitoring, and updating the current safety program. §821.29(o)(6).

D. Business Office: <u>(Each entry must be initialed by all POIC)</u>

_____ 1. Patient records must include accurate and current progress notes. §821.29 (p)(1).
_____ 2. Patient records must be kept private. §821.29(p)(2).
_____ 3. Patient records shall not be made available to anyone outside the facility without the patient's signed consent or as required by law. §821.29(p)(3).

_____ 4. Records must be kept a minimum of five years. §821.29(p)(4)

E. General: <u>(Each entry must be initialed by all POIC)</u>

_____ 1. Restroom and hand washing facilities must be available to the patient. §821.29(q)(1).
_____ 2. The facility can provide casting, measuring, fitting, repairs, and adjustments. §821.29(q)(2).

14. Affidavit. The information on this application is true and correct. I understand that providing false or misleading information in, with, or concerning the facility accreditation application may be cause for denial or loss of accreditation. I understand that knowingly providing false information on a government document is punishable by a state jail felony.

Signature of Applicant: _____ Date Signed: _____

Signature of Second Applicant: _____ Date Signed: _____

THE STATE OF _____)

COUNTY OF _____)

BEFORE ME, the undersigned authority, on this day personally appeared _____, Known to me to be the person whose name is subscribed to this instrument, and having been by me first sworn an oath, acknowledged that he or she had executed the same for the purposes and consideration therein expressed and that all statements are true and correct.

GIVEN under my hand and seal of office, this _____ day of _____, _____.

Notary public in and for _____ County, Texas or _____.

Seal of Notary

Signature of Notary: _____

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15. Fee. Enclosed is the non-refundable $ _____ application fee. (The fee rate was set by the Texas Board of Orthotics & Prosthetics and was not mandated by the Texas Legislature.)

Mail to: **Texas Board of Orthotics & Prosthetics**
PO Box 12197
Capitol Station
Austin, TX 78711-2197

Note: Please allow 4 to 5 weeks for processing, from the date that the facility application is mailed. An incomplete application will not be processed until all required fees and documents are received. Once a facility application is complete, it will be reviewed at the next scheduled meeting of the Board. The Board must approve the facility for accreditation before a license is issued.

All applications must include a scaled floor plan indicating the total square footage of the facility and clearly showing the location of the required parallel bars. Labeled photographs of each room, hallway, lab area, fabrication area, and facility entrance must be included with the application. Wheelchair accessibility must be clearly shown in all pictures except the lab and fabrication areas.