TEXAS DEPARTMENT OF LICENSING & REGULATION

P.O. Box 12157 • Austin, Texas 78711-2157

www.tdlr.texas.gov

ORTHOTISTS AND PROSTHETISTS FACILITY ACCREDITATION APPLICATION INSTRUCTIONS

Please read these instructions and the enclosed laws and rules governing the accreditation of Orthotist and/or Prosthetist 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 Texas Department of Licensing and Regulation (TDLR), 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.

If you are opening a new facility, or moving to a new location, please submit your application and fee as early as possible in order to ensure that your accreditation is issued prior to the first patient treatment date.

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 Department of Licensing and Regulation. Do not send cash.

1. FACILITY NAME – Full legal name of facility. If doing business under another name, please explain on a separate sheet of paper.
2. BUSINESS PHONE NUMBER – Write the telephone number, including the area code, of the business listed.
3. FAX NUMBER – Write a fax number, including the area code, where we can send you faxes.
4. EMAIL ADDRESS – Write your email address. Please provide your email address so the department may email license information and required notices to you. Your email address is confidential pursuant to the Texas Public Information Act, and the department will not share it with the public.
5. MAILING ADDRESS – Write your current mailing address. This is the address where we will send you mail. This address can be a post office box. You can add the zip plus-4 to help the postal service deliver mail more efficiently and accurately.
6. PHYSICAL ADDRESS – Write the physical address of your facility. A post office box cannot be used for this address. Once your license has been issued, you can only change the facility's physical address by applying for a new license.
7. TYPE OF OWNERSHIP – Check the box that indicates how your business is organized. You can find a description of the various types of business structures at: http://www.sos.state.tx.us/corp/businessstructure.shtml
   - **CORPORATION:** 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.
   - **SOLE PROPRIETOR OR PARTNERS:** 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.
   - **OTHER:** 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.
8. GENERAL BUSINESS INFORMATION –
   - Enter the total square footage of the facility.
   - Type of Facility; Check the appropriate item. Please check only one item: Orthotist, Prosthetist or Orthotist/Prosthetist.
   - Enter the date the first patient was treated. If no patients have been treated, put N/A.
   - Indicate whether the facility was previously accredited under another business name.
9. EMPLOYEE INFORMATION – 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.

10. SAFETY MANAGER – List the name(s) of the individual(s) that is/are designated as the facility safety manager(s). Include the individual's license or registration number if appropriate.
11. PRACTITIONER-IN-CHARGE – If you have an Orthotist 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 Prosthetist facility, you need a prosthetist-in-charge. If you have a Prosthetist / Orthotist 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). Also list any other facility at which your practitioner-in-charge is employed.
12. ATTESTATIONS – COMPLIANCE WITH REQUIREMENTS FOR ACCREDITED FACILITIES – The practitioner(s)-in-charge must complete this section. Each item, from A to E, must be initialed by the practitioner(s)-in-charge. **Do not leave any items blank**.
13. STATEMENT AND SIGNATURE OF PRACTITIONER-IN-CHARGE – Carefully read the statement before dating and signing your application.

SCHEDULE OF FEES

Type of License Requested	Fee
Prosthetist or Orthotist Facility Accreditation	$400
Prosthetist and Orthotist Facility Accreditation	$500

The following must be submitted along with the application, and approved, before your facility accreditation is issued.

☐ A scaled floor plan of the facility indicating the total square feet in the facility and clearly showing the location of parallel bars;

☐ Labeled photographs of each room and hallway clearly showing wheelchair accessibility and privacy protections for patients;

☐ Labeled photographs of the facility entrance clearly showing wheelchair accessibility; and

☐ Labeled photographs of all lab and fabrication areas.

Please make sure to take enough photographs so that we can see that your facility meets all the rule requirements for accreditation.

SEND YOUR COMPLETED APPLICATION AND REQUIRED DOCUMENTS TO:

Texas Department of Licensing and Regulation
P.O. Box 12157
Austin, TX 78711-2157

Documents submitted with your application will not be returned. Keep a copy of your completed application, all attachments, and you check or money order. Do not send cash.

For additional information and questions, please visit the Texas Department of Licensing & Regulation website at https://www.tdlr.texas.gov or reach Customer Service via webform where you can submit your request for assistance and include attachments as needed at https://www.tdlr.texas.gov/help. Customer Service can also be reached at (800) 803-9202 [in state only], (512) 463-6599, Relay Texas-TDD: (800) 735-2989 or Fax: (512) 463-9468. Customer Service Representatives are available Monday through Friday 7:00 a.m. until 6:00 p.m. Central Time (excluding holidays).

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ORTHOTISTS AND PROSTHETISTS FACILITY ACCREDITATION APPLICATION

DO NOT WRITE ABOVE THIS LINE

APPLICATION FEE FOR ORTHOTISTS OR PROSTHETISTS FACILITY ACCREDITATION; $400
APPLICATION FEE FOR ORTHOTISTS AND PROSTHETISTS FACILITY ACCREDITATION: $500
(APPLICATION FEE IS NON-REFUNDABLE)
This completed application must be accompanied by required documents and the application fee

1. Facility Name:

2. Business Phone Number: ( )
Area Code Number

3. Fax Phone Number: ( )
Area Code Number

4. Email Address:

(ex: johndoe@aol.com) See Instructions sheet for Disclosure)

5. Mailing Address:

(P.O. Box, Number, Street Name/Apartment Number)

City State Zip Code

6. Physical Address (PO box cannot be used for this address):

(Number, Street Name/Apartment Number)

City State Zip Code

7. Type of Ownership

☐ **Corporation:** List the name(s), social security number(s), address(es), 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.

☐ **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.

☐ **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

Name:

Social Security Number: Phone Number: ( ) Percentage of Ownership:

Mailing Address:

City State Zip

Name:

Social Security Number: Phone Number: ( ) Percentage of Ownership:

Mailing Address:

City State Zip

Name: _____

Social Security Number: _____ Phone Number: ( ) _____ Percentage of Ownership: _____

Mailing Address: _____

City _____ State _____ Zip _____

Name: _____

Social Security Number: _____ Phone Number: ( ) _____ Percentage of Ownership: _____

Mailing Address: _____

City _____ State _____ Zip _____

Name: _____

Social Security Number: _____ Phone Number: ( ) _____ Percentage of Ownership: _____

Mailing Address: _____

City _____ State _____ Zip _____

Name: _____

Social Security Number: _____ Phone Number: _____ Percentage of Ownership: _____

Mailing Address: _____

City _____ State _____ Zip _____

8. General Business Information: (If no patients have been treated, put N/A)

Total square footage of the facility: _____ Type of Facility: (check one) ☐ Orthotist ☐ Prosthetist ☐ Orthotist/Prosthetist

Date the first patient was treated: _____

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

9. Employee Information: (List the names and license numbers of all individuals, licensed under the Act, who practice in this facility. Add additional sheets if necessary.) (please print)

Name: _____ License Number: _____

Name: _____ License Number: _____

Name: _____ License Number: _____

Name: _____ License Number: _____

Name: _____ License Number: _____

Name: _____ License Number: _____

Name: _____ License Number: _____

Name: _____ License Number: _____

Name: _____ License Number: _____

Name: _____ License Number: _____

Name: _____ License Number: _____

Name: License Number:

10. 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)). (please print) Use N/A, if individual is not licensed or registered.

Name: _____ License Number: _____

Name: _____ License Number: _____

Name: _____ License Number: _____

Name: License Number:

11. Practitioner-In-Charge: (List the name(s) and license number(s) of the prosthetist and/or orthotist who is ON-SITE and in charge)

☐ Orthotist-In-Charge

Name: (please print) _____ License Number: _____

Signature: _____ Date: _____

☐ Prosthetist-In-Charge

Name: (please print) _____ License Number: _____

Signature: _____ Date: _____

☐ Prosthetist/Orthotist-In-Charge

Name: (please print) _____ License Number: _____

Signature: _____ Date: _____

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.

Practitioner Name: (please print) _____ Indicate if you are Designated as the Practitioner-In-Charge: ☐ Yes ☐ No

Facility Name: _____ Address: _____

Practitioner Name: (please print) _____ Indicate if you are Designated as the Practitioner-In-Charge: ☐ Yes ☐ No

Facility Name: _____ Address: _____

Practitioner Name: (please print) _____ Indicate if you are Designated as the Practitioner-In-Charge: ☐ Yes ☐ No

Facility Name: Address:

12. Attestations:

In accordance with the rules adopted by the Texas Department of Licensing and Regulation (TDLR), Accreditation of Prosthetist and Orthotist 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 TDLR' s rules concerning Accreditation of Prosthetist and Orthotist Facilities that can be verified by site inspection.** The applicable agency 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.

_____ 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 TDLR is the property of TDLR and must be surrendered on demand.

_____ 3. The facility is subject to random inspection to verify compliance with the Act and rules at any time, by authorized TDLR personnel. TDLR may also conduct inspections if the agency receives a complaint regarding the facility.

_____ 4. The facility is under the clinical on-site direction of a prosthetist, orthotist, or prosthetist / orthoptist licensed by TDLR in the discipline in which the facility sought accreditation, and that that person supervises the provision of Prosthetists and/or Orthotists in accordance with the Act and rules and is the person in charge.

_____ 5. The facility shall report all changes to TDLR 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.

_____ 6. The facility is required to comply with the Act and rules of TDLR.

_____ 7. Consumer complaint information notices. All licensees, registrants and accredited facilities, excluding facilities that a licensee visits to treat patients, such as hospitals, nursing homes or patients' homes, shall prominently display a consumer complaint notice or sign in a waiting room or other area where it shall be visible to all patients. Lettering shall be at least one-fourth inch, or font size 30, in height, with contrasting background, containing the department's name, website, mailing address, and telephone number for the purpose of directing complaints to the department regarding a person or facility regulated or requiring regulation under the Act. Script or calligraphy prints are not allowed. The notice shall be worded as specified by the department.

An accredited facility must display a visible sign with its hours of operation, including:
(A) hours of normal business operation, and when appropriate;
(B) information regarding temporary closure, including holidays, or for periods during business hours, including specific dates and times of the closure and emergency contact information.

_____ 8. The facility accreditation shall not be transferred or sold to another facility or owner, nor transferred to a different location.

_____ 9. The facility agrees to comply with the change in ownership requirements.

_____ 10. The facility must renew its accreditation every two years. TDLR 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 TDLR.

_____ 11. The renewal shall be affixed to or displayed with the original accreditation and is the property of TDLR.

_____ 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.

_____ 13. A revocation or suspension of an accreditation may affect all facilities accredited under the same name, the same owners, or the same corporation.

B. Facility Cleanliness: (Each entry must be initialed by all POIC)

_____ 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 Prosthetist and Orthotist care.

_____ 2. Patient examination and treatment rooms shall be cleaned after each patient is seen.

_____ 3. Hand soap, hand towels or hand dryers must be available at the sinks used by employees and patients.

_____ 4. Exam tables must have disposable covers or disinfected surfaces.

_____ 5. Appropriate gloves and disinfectants for disease control must be available in examination rooms and treatment areas.

_____ 6. Patient waiting areas must be separate from the other areas.

_____ 7. Chairs with armrests must be provided in waiting rooms.

_____ 8. A telephone must be made available for patient use.

_____ 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.

_____ 10. At least one set of parallel bars and a mirror for patient ambulation trials must be provided in each facility.

C. Safety: (Each entry must be initialed by all POIC)

_____ 1. Chairs with armrests must be provided in examination / treatment rooms. Chairs without armrests or wheels must be provided upon patient request.

_____ 2. Safety equipment (safety glasses / goggles and dust masks) must be available to persons working in the facility.

_____ 3. Proper machine use and training must be provided.

_____ 4. Safety guards on machines must always be in place.

_____ 5. Lab / fabrication areas must be separated from other areas by walls and/or doors and have adequate ventilation and lighting.

_____ 6. If smoking is permitted, policies and procedures are in place to control smoking materials.

_____ 7. A minimum of one licensee or registrant must be assigned to each facility to act as safety manager. The safety manager is responsible for developing, carrying out, and monitoring the safety program.

D. Business Office: (Each entry must be initialed by all POIC)

_____ 1. Patient records must include accurate and current progress notes.

_____ 2. Patient records must be kept private.

_____ 3. Patient records shall not be made available to anyone outside the facility without the patient's signed consent or as required by law.

_____ 4. Records must be kept a minimum of five years.

E. General: (Each entry must be initialed by all POIC)

_____ 1. Americans with Disabilities Act compliant restroom and hand washing facilities must be safe and accessible to the patient.

_____ 2. The facility must have the equipment, tools, and materials to provide casting, measuring, fitting, and major repairs and adjustments.

13. STATEMENT AND SIGNATURE OF PRACTITIONER-IN-CHARGE (POIC)

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 POIC | Date Signed

Signature of POIC | Date Signed