TEXAS DEPARTMENT OF LICENSING & REGULATION

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

www.tdlr.texas.gov

ORTHOTISTS AND PROSTHETISTS CHANGE OF ON-SITE PRACTITIONER IN CHARGE INSTRUCTIONS

The application must be completed and signed by the applicant. An application is not considered complete and will not be processed until all required items have been submitted. All information provided must be typed or printed.

1. NAME OF THE FACILITY – Provide the name of the facility as it should appear on your license
2. TYPE OF FACILITY – Place a check in the of the type of facility you are changing information on.
3. ACCREDITATION NUMBER – Provide the facilities accreditation number.
4. MAILING ADDRESS – Provide your current mailing address. This is the address where we will send you mail. This address can be a post office box. Add the zip plus-4 to help the postal service deliver mail more efficiently and accurately.
5. PHYSICAL ADDRESS – This is the physical location of your residence. Do not use a post office box for this address.
6. PHONE NUMBER – Provide a telephone number, including the area code, where we can reach you during the day. This may be your office phone number where we can leave a message.
7. EMAIL ADDRESS – Provide 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.
8. NAME OF ON-SITE PRACTITIONER IN CHARGE OF ORTHOTISTS – List the name of the on-site Orthotist in charge.
9. NAME OF ON-SITE PRACTITIONER IN CHARGE OF PROSTHETISTS – List the name of the on-site Prosthetist in charge.
10. STATEMENT OF APPLICANT – Complete all requested contact information and carefully read the statement before signing and dating form.

SEND YOUR COMPLETED APPLICATION AND REQUIRED DOCUMENTS TO:

TDLR
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 your check or money order. Do not send cash.

For additional information and questions, visit the ***TDLR website*** or reach Customer Service via ***webform***. The webform will allow you to submit your request for assistance and include attachments needed. Customer Service Representatives are available Monday through Friday (excluding holidays) at (800) 803-9202 (in state only), (512) 463-6599, or Relay Texas-TDD: (800) 735-2989.

TDLR Public Information Act Policy:
This document is subject to the Texas Public Information Act. With certain exceptions, information in this document may be made available to the public. For more information, view the ***TDLR Public Information Act Policy***.

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ORTHOTISTS AND PROSTHETISTS
CHANGE OF ON-SITE PRACTITIONER IN CHARGE REQUEST

1. Name of the Facility:

2. Type of Facility:

☐ Orthotic Facility ☐ Prosthetic Facility ☐ Orthotic/Prosthetic Facility

3. Accreditation#:

4. Facility Mailing Address:

P.O. Box, Number, Street Name, Suite Number/Apartment Number | City | State | Zip Code

5. Facility Physical Address: (P.O. Box cannot be used for this address)

Number, Street Name, Suite Number/Apartment Number | City | State | Zip Code

6. Facility Phone Number:

(Area Code) Phone Number

7. Facility Email Address:

(See instruction sheet for disclosure information)

8. Name of On-Site Practitioner in Charge (PIC) of *Orthotists*:

Orthotist License #:

Orthotists Signature**:**

Date became PIC at this facility:

9. Name of On-Site Practitioner in Charge (PIC) of *Prosthetists*:

Prosthetist License #:

Prosthetists Signature**:**

Date became PIC at this facility:

10. STATEMENT OF PERSON COMPLETING THIS FORM

I declare that all information on this form is accurate and true. I understand that providing false information on this request may result in denial and/or revocation of the license and the imposition of administrative penalties.

Form Completed By:

First Name, Middle Name, Last Name

Title of the person completing this form:

Phone Number:

(Area Code) Phone Number

Email Address:

(See Instruction Sheet for Disclosure Information)

Signature of person completing this form

Date Signed