



Physical Therapy Board of California

STATE AND CONSUMER SERVICES AGENCY - GOVERNOR EDMUND G. BROWN JR.

Physical Therapy Board of California

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SPONSORED FREE HEALTH CARE EVENTS

APPLICATION FOR REGISTRATION OF SPONSORING ENTITY Business & Professions Code Section 901

In accordance with California Business and Professions (B&P) Code section 901(d), a non-government organization administering an event to provide health care services to uninsured and underinsured individuals at no cost may include participation by certain health care practitioners licensed outside of California if the organization registers with the California licensing authorities having jurisdiction over those professions. This form shall be completed and submitted by the sponsoring organization **at least ninety (90) calendar days prior to the sponsored event.** *Note that the information required by B&P Code section 901(d) must also be provided to the county health department having jurisdiction in each county in which the sponsored event will take place.*

Only one registration form per event should be completed and submitted to the Department of Consumer Affairs (DCA) (address and contact information on last page). The DCA will forward a copy of the completed registration form to each of the licensing authorities indicated on this form.

PART A – ORGANIZATIONAL INFORMATION

1. Organization Name: _____

2. Organization Contact Information (*use principal office address*):

Address Line 1

Phone Number of Principal Office

Address Line 2

Alternate Phone Number

City, State, Zip

Fax Number

County

Website

Organization Contact Information in California (*if different*):

Address Line 1

Phone Number

Address Line 2

Alternate Phone Number

City, State, Zip

Fax Number

County

3. Type of Organization:

a. Organization's Tax Identification Number*: _____
(*B&P Code Section 30 and Public Law 94-455 [(42 USCA(c)(2)(c)] authorizes collection of your FEIN. Applications for Registration will not be processed until a valid U.S. identification number is received.)

b. Is the organization operating pursuant to Section 501(c)(3) of the Internal Revenue Code?
_____ Yes _____ No

c. If not, is the organization a community-based organization? _____ Yes _____ No
(Note: A "community based organization" means a public or private nonprofit organization that is representative of a community or a significant segment of a community, and is engaged in meeting human, educational, environmental, or public safety community needs.)

d. If a community-based organization, please describe the mission, goals and activities of the organization (*attach separate sheet(s) if necessary*): _____

PART B – RESPONSIBLE ORGANIZATION OFFICIALS

Please list the following information for each of the principal individual(s) who are the officers or officials of the organization responsible for operation of the sponsoring entity.

Individual 1:

Name

Title

Address Line 1

Phone Number

Address Line 2

Alternate Phone Number

City, State, Zip

Fax Number

County

E-mail Address

Individual 2:

Name

Address Line 1

Address Line 2

City, State, Zip

County

Title

Phone Number

Alternate Phone Number

Fax Number

E-mail Address

Individual 3:

Name

Address Line 1

Address Line 2

City, State, Zip

County

Title

Phone Number

Alternate Phone Number

Fax Number

E-mail Address

(Attach additional sheets if needed to list additional principal organizational individuals)

PART C – EVENT DETAILS

1. Name of event, if any: _____

2. Date(s) of event not to exceed ten (10) calendar days: _____

3. Location(s) of the event (be as specific as possible, including address):

4. Describe the intended event, including a list of all types of healthcare services intended to be provided (*attach additional sheet(s) if necessary*): _____

5. Attach a list of all out-of-state health care practitioners who you currently believe intend to apply for authorization to participate in the event. The list should include the name, profession, and state of licensure of each identified individual.

___ *Check here to indicate that the list is attached.*

6. Please check each licensing authority that will have jurisdiction over an out-of-state licensed health practitioner who intends to participate in the event:

- | | |
|-------------------------------------|--|
| ___ Acupuncture Board | ___ Physical Therapy Board |
| ___ Board of Behavioral Sciences | ___ Board of Podiatric Medicine |
| ___ Board of Chiropractic Examiners | ___ Board of Psychology |
| ___ Dental Board | ___ Board of Registered Nursing |
| ___ Dental Hygiene Committee | ___ Respiratory Care Board |
| ___ Medical Board | ___ Speech-Language Pathology, Audiology & Hearing Aid Dispensers Board |
| ___ Naturopathic Medicine Committee | ___ Veterinary Medical Board |
| ___ Board of Occupational Therapy | ___ Board of Vocational Nursing & Psychiatric Technicians |
| ___ Board of Optometry | ___ Other: _____ |
| ___ Osteopathic Medical Board | |
| ___ Board of Pharmacy | |
| ___ Physician Assistant Committee | |

7. Please remember that:

Each individual out-of-state practitioner must request authorization to participate in the event by submitting an application (Form 901-B) **to the applicable licensing board/committee.**

The organization will be notified in writing whether authorization for an individual out-of-state practitioner has been granted.

PART D – CERTIFICATION STATEMENTS

I understand the recordkeeping requirements imposed by California Business & Professions Code section 901 and the applicable sections of Title 16, California Code of Regulations for the agencies listed above to maintain records, in either electronic or paper form, at the sponsored event and for five (5) years in California.

I understand that our organization must file a report with each applicable board/committee within fifteen (15) calendar days of the completion of the event.

I certify under penalty of perjury under the laws of the State of California that the information provided on this form and any attachments is true and current and that I am authorized to sign this form on behalf of the organization.

Name Printed

Title

Signature

Date

PART E – MAILING INSTRUCTIONS

This form and any attachments shall be submitted to:

Department of Consumer Affairs
Attn: Sponsored Free Health Care Events
1625 North Market Boulevard, Suite S-204
Sacramento, CA 95834

(7/2011)