



## SPONSORED FREE HEALTH CARE EVENTS

### REGISTRATION OF SPONSORING ENTITY UNDER BUSINESS & PROFESSIONS CODE SECTION 901

In accordance with California Business and Professions 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 90 calendar days prior to the sponsored event.** *Note that the information required by Business and Professions 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 form (per event) should be completed and submitted to the Department of Consumer Affairs. The Department of Consumer Affairs will forward a copy of the completed registration form to each of the licensing authorities indicated on this form.]

#### PART 1 – 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

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Website

\_\_\_\_\_  
County

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

\_\_\_\_\_  
Address Line 1

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Address Line 2

\_\_\_\_\_  
Alternate Phone

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
County

3. Type of Organization:

Is the organization operating pursuant to Section 501(c)(3) of the Internal Revenue Code?     \_\_\_ Yes     \_\_\_ No

If not, is the organization a community-based organization\*?     \_\_\_ Yes     \_\_\_ No

Organization's Tax Identification Number \_\_\_\_\_

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

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\* 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.

**PART 2 – 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

\_\_\_\_\_  
Address Line 1

\_\_\_\_\_  
Address Line 2

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
County

\_\_\_\_\_  
Title

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Alternate Phone

\_\_\_\_\_  
E-mail address

Individual 2:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address Line 1

\_\_\_\_\_  
Address Line 2

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
County

\_\_\_\_\_  
Title

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Alternate Phone

\_\_\_\_\_  
E-mail address

Individual 3:

\_\_\_\_\_  
Name  
\_\_\_\_\_  
Address Line 1  
\_\_\_\_\_  
Address Line 2  
\_\_\_\_\_  
City, State, Zip  
\_\_\_\_\_  
County

\_\_\_\_\_  
Title  
\_\_\_\_\_  
Phone  
\_\_\_\_\_  
Alternate Phone  
\_\_\_\_\_  
E-mail address

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

<b>PART 3 – EVENT DETAILS</b>
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1. Name of event, if any: \_\_\_\_\_

2. Date(s) of event (not to exceed ten 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 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               | ___ Physician Assistant Committee |
| ___ Board of Behavioral Sciences    | ___ Physical Therapy Board        |
| ___ Board of Chiropractic Examiners | ___ Board of Podiatric Medicine   |
| ___ Dental Board                    | ___ Board of Psychology           |
| ___ Dental Hygiene Committee        | ___ Board of Registered Nursing   |

\_\_\_ Medical Board of California  
\_\_\_ Naturopathic Medicine Committee  
\_\_\_ Board of Occupational Therapy  
\_\_\_ Board of Optometry  
\_\_\_ Osteopathic Medical Board  
\_\_\_ Board of Pharmacy

\_\_\_ Respiratory Care Board  
\_\_\_ Speech-Language Pathology,  
Audiology & Hearing Aid Dispensers  
Board  
\_\_\_ Veterinary Medical Board  
\_\_\_ Board of Vocational Nursing &  
Psychiatric Technicians

**Note:**

- 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.
- I understand the recordkeeping requirements imposed by California Business and 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 both 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.

This form, any attachments, and all related questions shall be submitted to:  
Department of Consumer Affairs  
Attn: Sponsored Free Health Care Events  
1625 North Market Blvd.  
Sacramento, CA 95834

I certify under penalty of perjury 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