Texas Department of State Health Services

Jennifer A. Shuford, M.D., M.P.H.
Commissioner

Federal 340B Drug Discount Program Assurance Form

________________________ (Participating Clinic's Full Legal Name including dba) makes the following assurances in support of its participation in the Federal 340B Drug Discount Program (the "Program"):

1. Utilize Department State Health Services' (DSHS) Central Distribution Model for all Program medications, made available through DSHS' Pharmacy Inventory & Ordering System (PIOS) platform.

2. DSHS' Medications, Pharmacy Branch will order, receive and distribute medications to authorized sub-grantees.

3. Signed a Memorandum of Understanding with DSHS to participate in the Program, agreeing to all terms and conditions.

4. Complies with all Program requirements set by federal and state laws, rules and regulations, the Health Resources and Service Administration (HRSA) and DSHS.

By signing below, designee acknowledges they have the requisite authority to execute this form on behalf of the named party.

_________________________   _________________
Signature of Program Designee   Date

____
Typed or Printed Name

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