Dan Alfaro & Associates

ABOGADOS

DAN ALFARO

WILLIAM E. OWEN; OF COUNSEL

January 3, 1992

Ms. Kathleen White
527 S. Shoreline
Corpus Christi, TX 78401

Dear Kathleen:

I am enclosing a copy of the letter which I wrote four years ago to some Hispanic members of our community in connection to the Corpus Christi Yacht Club. Since that time my feelings have not changed. I believe that people should have an absolute right to meet privately, to have private organizations, and to exclude anyone they wish from those private institutions.

I think it is embarrassing and belittling for some of us to force ourselves into organizations with whom we have little or nothing in common and who might not wish to have our presence. Furthermore, Mexicans are prone to sea sickness and generally know little about sailing.

I think you are an intelligent lady who is doing a great job as my accountant but I still don't think the food at the Yacht Club is any better than the Chinese food at the Mandarin Inn.

Dan Alfaro

DA/mg

P.S. Read and approved by Dr. Xico Garcia.

3765 S. Alameda, Suite 101 • Corpus Christi, Texas 78411
512/888-5273 • 1-800-321-2957 • Fax (512) 888-5278

cc: Mr. Jorge Rangel
Attorney at Law
719 S. Shoreline
Corpus Christi, TX 78403

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621 E. Sinton
Sinton, TX 78387

Dan Alfaro & Associates
A PROFESSIONAL CORPORATION
Attorneys at Law

Dan Alfaro

2818 South Port
Corpus Christi, Texas 78405
512/888-5273

September 15, 1987

Dr. Hector P. Garcia
Dr. Xico P. Garcia
Dr. Cleo Garcia
Mr. Ruben Bonilla
Mr. Tony Canales
Mr. Rudy Garza
Mr. Armando Ortiz
Mr. Jorge Rangel
Mr. Jacob Munoz
Mr. Jose Longoria
Dr. Robert Vela
Dr. Julio Vela
Mr. Leo Guerrero
Mr. David Berlanga, Sr.
Mr. Albert A. Pena, III
Mr. Manuel Davila
Dr. Angel Saenz
Mr. Ciro "Cid" Lopez
Dr. Humberto Garcia
Dr. Joe Jimenez
Mr. David Diaz
Mr. Albert Huerta
Mr. Victor Gonzalez
Dr. Arnold Villarreal
Mr. Raymond Rodriguez
Mr. Tony Bonilla
Mr. David Bonilla
Mr. Jon Bonilla
Rep. Eddie Cavazos
Rep. Hugo Berlanga
Sen. Carlos Truan
Mr. Ernest Briones
Mr. Frank Mendez
Dr. Octavio Garcia
Mr. Pedro Garcia
Dr. Billy Rios
Mr. Joe De Leon
Dr. Eliud J. Fuentes
Dr. Carlos Canales

Gentlemen:

I admire and respect the efforts of the gentlemen who are bringing attention to the segregated status of the Corpus Christi Yacht Club; however, the situation has been in existence for many years and does not surprise nor alarm me. You can change the rules but you cannot alter the mentalities. I, for one, would not consider membership at the Yacht Club nor keep my boat there if I were a member. The facilities are rather small and the food isn't that good.

Dr. Xico and I have promised $5,000 each for the purchase of land and construction of a private yacht club. With one hundred participants, we can raise $500,000 for the land and partial construction.

We trust that the concern over this serious problem does not dissipate and get blown away by the first norther, and that some of you gentlemen would consider being members of a committee that would develop this proposal.

If I have insulted the sensitivities of those whose earning power or social equilibrium is affected by the anglo community, I apologize.

Dan Alfaro

Dr. Xico P. Garcia

MEMORIAL MEDICAL CENTER #25778
P. O. Box 5280 FAMILY PRACT
Corpus Christi, Texas 78465-5280
APPLICATION FOR REAPPOINTMENT FOR 1992-1993

In order to process your reappointment to the Medical Staff, the following information is to be completed. Please return this form to the Medical Staff Office.

I. PERSONAL IDENTIFICATION DATA

HECTOR P. GARCIA, MD
1315 BRIGHT
CORPUS CHRISTI, TX 78405

If not a citizen of the U.S., please indicate the status of your visa: _____

II. PROFESSIONAL DATA Social Security: 464-58-3165

A. LICENSE/PERMIT DATA

Please make changes if information is not correct:

1. License Number: B5778 Expires: 11/30/92
2. DEA Number: AG0941523 Expires: 09/30/95
3. DPS Number: T0004810 Expires: 03/31/93
4. Malpractice Insurance Expires: 07/09/93

Phone Numbers
OFFICE: 883-1789
EXCHG: 884-0661
HOME: UNLISTED

PLEASE SUBMIT COPIES OF CURRENT CERTIFICATES IF THE ABOVE SHOWS THEY ARE EXPIRED.

B. Practice limited to Family Practice

C. CONTINUING EDUCATION UPDATE: List all professional meetings attended, formal continuing education and professional training received in the past two years. Use separate sheet if necessary and include certificates if applicable.

See copies enclosed. (17 hours)

III. DISCIPLINARY ACTIONS

Since your appointment or last reappointment, have any of the following ever been, or are any currently in the process of being denied, revoked, suspended, reduced, limited, placed on probation, not renewed, voluntarily or involuntarily relinquished? **IF YOUR ANSWER TO ANY OF THESE QUESTIONS IS YES, PLEASE PROVIDE FULL EXPLANATION ON A SEPARATE SHEET.**

License to practice in any state	Yes ____	No ✓
Academic appointment	Yes ____	No ✓
Clinical Privileges	Yes ____	No ✓
DEA/DPS Registration	Yes ____	No ✓
Membership on any hospital medical staff	Yes ____	No ✓
Professional society membership	Yes ____	No ✓
Professional liability insurance	Yes ____	No ✓
Fellowship/board certification	Yes ____	No ✓
HMOs, PPOs or Managed Health Care Plans	Yes ____	No ✓
Any other type of professional sanction	Yes ____	No ✓
Has there been a felony criminal charge brought against you?	Yes ____	No ✓

IV. PROFESSIONAL ASSOCIATIONS AND TEACHING APPOINTMENTS

Since your appointment or last reappointment to the Medical Staff:

A. List all local, state and national professional societies in which you have obtained membership: Nueces County Med Socict Tex. Med Association Am. Med Assoc.

Have you been denied membership or renewal thereof, or been subject to disciplinary proceedings in any professional organization? Yes____ No✓

If yes, please provide full explanation on separate sheet.

B. Teaching appointments (institution/position): 0

C. Board Certification:

1. List specialty boards by which you are currently certified: 0 Year Certified_____
2. List specialties in which you are board eligible_____
3. Not certified: _____

D. Hospital Affiliations:

List all other hospitals at which you have current or pending appointments to the medical staff.

Hospital	Address	Staff Category
Mem. Med Center		Active. Staff

V. PROFESSIONAL LIABILITY DATA

A. MMC requires that staff members carry malpractice insurance with minimum limits of $100,000/$300,000. Please have your insurance carrier submit a certificate which indicates you have minimum coverage OR submit a copy of the face sheet of your policy.

B. Have you been subject to medical litigation within the past two years? Yes____ No✓

C. Is there any medical litigation currently pending against you? Yes____ No✓

D. Since your appointment or last reappointment to the Medical Staff:

1. Have any judgments been taken or settlements made in your behalf in professional liability cases? Yes____ No✓
2. Has your professional liability insurance coverage been terminated by action of the insurance agency? Yes____ No✓
3. Have you been denied professional insurance coverage? Yes____ No✓

IF YOUR ANSWER TO ANY OF THE ABOVE QUESTIONS IS YES, PLEASE FILL OUT THE ATTACHED ADDENDUM

VI. HEALTH STATUS

A. Date of last complete physical examination: Oct 20, 92

B. Present health status: Good ✓ Fair______ Poor______
If fair or poor, state reasons on separate sheet

C. Do you presently have, or have had, any illness or injury, a physical or mental condition, including alcohol or drug dependence, that affects or is reasonable likely to affect your ability to perform professional or medical staff duties appropriately?
Yes _____ No ✓

D. Are you currently under any limitations, in terms of activity or work load? Yes____ No ✓

E. Are you currently under the care of a physician? Yes ✓ No____

IF YES TO ANY OF THE ABOVE QUESTIONS, PLEASE SUBMIT EXPLANATION OF THE DETAILS ON A SEPARATE SHEET. Dr. Robt. Jordran for for Hernia/Hypertension STATUS.

VII. STAFF CATEGORY
I wish to apply to the following staff category:

✓ Active Staff (full privileges) _____Emeritus Staff (65 yrs. or older)

_____Courtesy Staff (12 admissions per year) (Requires active staff at another hospital) _____Academic Staff (teaching only)

_____Regional Courtesy (out of town) _____Honorary Staff (Retired)

J

VIII. APPLICANT'S STATEMENT AND SIGNATURE

1 I desire reappointment to the medical staff of Memorial Medical Center and agree to abide by the Bylaws, Rules and Regulations and policies of the hospital. I further
2. agree to report any changes in my health status that would affect my ability to practice medicine. I certify that the preceding information is true and correct and that any significant misstatements in, or omissions from, this application constitute cause for
3. denial of reappointment or cause for dismissal from the medical staff.

4. I hereby further authorize and consent to the release of information by other hospitals, malpractice carriers, physicians, or other persons to Memorial Medical Center in
5. reference to my professional competence, character or moral ethical qualifications.

6.

7.

Hector P Garcia MD 10/22/92
HECTOR P. GARCIA, MD Date

8.

I hereby make application to the active staff of Memorial Medical Center.

MEMORIAL MEDICAL CENTER
Corpus Christi, Texas
Family Practice Department
Delineation of Privileges

Privileges in the Family Practice Department are granted for both clinical and specific procedures. Initial application by new members or requests by current staff members for additional privileges should be accompanied by documentation of training and experience. Any physician may request additional privileges at any time, subsequent to the completion of additional training. All physicians requesting privileges in this department are subject to the same application process.

All privileges held by current Active Staff members in the Department of Family Practice on the date of this document will be preserved.

Privileges will be evaluated according to the following classes. Please check those for which you are applying and provide the information indicated.

____ CLASS I
Any care or procedure that are deemed necessary in the event of an emergency. A physician is recommended for these privileges by virtue of his/her basic medical education, verification of professional degree, and holding of an unqualified license to practice medicine.

____ CLASS II
Care of illness or medical problems that are not usually serious threats to life. If doubt exists as to diagnosis, management, or treatment; or if response to treatment is not as expected; consultation is expected. Privileges are recommended on the basis of satisfaction of requirements for CLASS I plus verification of at least one year of postgraduate training in an accredited family practice or general practice residency or internship.

✓ CLASS III
Procedures or care of illness/medical problems detailed in the following list of privileges. These privileges are recognized as within the purview of Family Practice as defined by the American Board of Family Practice for eligibility for board certification. Privileges are recommended on the basis of satisfaction of requirements for CLASS II plus verification of completion of an accredited three year residency in family practice or documentation of five years of practice experience that included Ob/Gyn, Pediatric, and In-patient practice.

A. Anesthesiology

Venous cutdowns and central venous access
Arterial punctures and cannulation

B. Gynecology

D & C -- Diagnostic or therapeutic
Treatment of Bartholin's Cyst
Hymenotomy
Gynecologic infections

STATEMENT OF APPLICANT

I certify that I have not requested any privileges for which I am not eligible by reason of training or experience. I agree to submit any requested documentation of such training or experience.

Walter P Burnard MD

Applicant's Signature _____ Date _____

I recommend approval of the clinical privileges requested, with exception, if noted.

Chairman, Family Practice Dept. _____ Date _____

Chairman, Credentials Committee _____ Date _____

MEMORIAL MEDICAL CENTER

2606 Hospital Blvd., • Corpus Christi, Texas 78405-1818 • (512) 881-4000 • FAX (512) 881-4102

AUTHORIZATION FOR RELEASE OF INFORMATION

NAME: _____

SPECIALTY: _____

The undersigned does hereby join in the request to the addressee of this letter that the Credentials Committee of Memorial Medical Center - Corpus Christi, Texas be provided with the requested information; and, in consideration for compliance with this request, the undersigned does hereby release the addressee and any and all individuals providing the requested information from any and all actions or causes of actions for damages arising out of or in any way connected with the compliance of this request.

PHYSICIAN'S SIGNATURE: [signature] M.D.

DATE: OCT 22 92

MEMORIAL MEDICAL CENTER
Corpus Christi, Texas

ADDENDUM TO APPLICATION FOR REAPPOINTMENT TO THE MEDICAL STAFF

DETAIL SHEET

Settlements on Malpractice Claims None

1. List the allegations _____

2. Date of Occurrence _____

3. Name of Institution _____

4. Amount of settled claim _____

5. Name and address of insurance carriers involved _____

Judgements/Jury Awards None

1. Title of court case _____
2. The court case number _____
3. The venue of the case (place where court case took place) _____
4. Allegations listed in complaint _____
5. Date of Incident leading to complaint _____
6. Place of Incident _____
7. Name and address of malpractice insurance carrier _____
8. Amount of jury award or amount awarded by the court _____

Date: 10/22/92 Signature: Victor P Garcia MD

Name (please print): Dr Victor P Garcia