



**State of Tennessee**  
**Health Facilities Commission**

502 Deaderick Street, Andrew Jackson Building, 9<sup>th</sup> Floor, Nashville, TN 37243  
[www.tn.gov/hfc](http://www.tn.gov/hfc) Phone: 615-741-2364 [hsda.staff@tn.gov](mailto:hsda.staff@tn.gov)

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**INITIAL APPLICATION FOR LICENSE OF SERVICES  
FOR PHYSICIAN OFFICES**

**1. NAME AND PHYSICAL ADDRESS OF PHYSICIAN OFFICE OF SERVICE**

West Tennessee Bone and Joint Clinic, PC

Name

50 Capital Avenue

Address

Jackson

TN

38305

City

State

ZIP

**2. CEO/ADMINISTRATOR OF PROVIDER**

Chip Anderson

CEO

Name

Title

handerson@wtbjc.com

Email Address

West Tennessee Bone and Joint Clinic, PC

Company Name

50 Capital Avenue

Address

Jackson

TN

38305

City

State

ZIP

731-410-2319

Phone Number

**3. BILLING INFORMATION FOR FACILITY**

Adam Kelley Controller  
Name Title

payables@wtbjc.com  
Email Address

West Tennessee Bone and Joint Clinic, PC  
Company Name

50 Capital Avenue  
Address

Jackson TN 38305  
City State ZIP

731-410-2306  
Phone Number

**4. OWNERSHIP OF FACILITY**

West Tennessee Bone and Joint Clinic, PC  
Name of Owner

50 Capital Avenue  
Address

Jackson TN 38305  
City State ZIP

731-410-2319  
Phone Number

Legal Entity:

<input type="checkbox"/> Individual	<input type="checkbox"/> Limited Liability	<input checked="" type="checkbox"/> Corporation (For Profit)
<input type="checkbox"/> Corporation (Not for Profit)	<input type="checkbox"/> Government	<input type="checkbox"/> Limited Partnership
<input type="checkbox"/> Joint Venture	<input type="checkbox"/> Professional Limited Liability Company	
<input type="checkbox"/> Other _____		

List name(s) and addresses of individual owners, partners, directors of the corporation, or head of the government entity. (If more than two (2), please use ATTACHMENT – B.)

See Attachment - B

(1) Name

Address

City

State

ZIP

(2) Name

Address

City

State

ZIP

If a government/county owned facility, does the administrator have authority to act on behalf of the government/county as it relates to the operation of this facility?  Yes  No

If no, why:

Is this facility chain affiliated?  Yes  No

If a corporation, is there a holding company?  Yes  No

If yes, please complete the following information of the holding company.

Name of Owner

Address

City

State

ZIP

Phone Number

Are any owners of the disclosing entity also owners of other health care facilities in Tennessee and/or other states?  Yes  No

If yes, list their names and addresses of all facilities.:

Is there a contract with a management firm to operate this facility?  Yes  No

If yes, please specify the dates of the contract and complete the firm's information.

Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

\_\_\_\_\_  
Name of Firm

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State ZIP

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

**5. LEGAL**

If any of the items within this section (LEGAL), please identify, explain, and provide documentation of the item(s) noted if response is "yes". Have either the licensed entity for any of the other health care facilities in Tennessee and/or other states listed, or the management firm listed been subjected to any of the following within the past five (5) years?

**Licensure**

- Denied a License  Yes  No
- Had a license suspended or revoked by any state licensure agency?  Yes  No
- Been subject to a final order or judgement in a state licensure action?  Yes  No

**Convictions**

- If convicted of a criminal offense related to that person's involvement in any program under any state or federal health care program – including Medicare, Medicaid, and TriCare?  Yes  No

**Exclusion**

- Excluded from participation in federal health care programs – Medicare, Medicaid, CHIP, or TriCare – in the past?  Yes  No
- (Excluded is defined as a provider or entity has been told by the Department of Health and Human Services, Office of the Inspector General (HHS-OIG) that they may no longer be a provider for any federally funded healthcare.)  Yes  No

**Termination/Suspension**

- Suspended or terminated from participation in Medicare or Medicaid/TennCare programs?  Yes  No

**Fraud and Abuse**

- Paid through settlement, or civil or criminal fines, any monies to the federal government or any state as a result of any administrative or judicial proceeding based on allegations of fraud or abuse involving claims related to the provision of health care items and services?  Yes  No

**Corporate Integrity Agreement**

- Is presently an entity covered by and subject the terms of a corporate integrity agreement?  Yes  No  
(If yes, please provide a copy of CIA.)

**Bankruptcy**

- Filed bankruptcy under any provision of the United States Bankruptcy Code:  Yes  No

**Civil Monetary Penalty (CMP)**

- Paid to the Centers for Medicare and Medicaid Services or any state Medicaid agency a civil money penalty equal to or greater than \$250,000 as a result of an enforcement action during a survey?  Yes  No

6. On the following items, check all appropriate services to be licensed.

x **ESTABLISHING MRI UNIT/SERVICE:** (If more than one unit, use ATTACHMENT – A.)

Physical Address of Service: 50 Capital Ave, Jackson TN 38305

Name Brand of Unit Philips

Tesla 1.5

Type (i.e. Close, Short Bore, etc.) Closed

Unit's Serial Number 48827

Will the MRI Unit be Accredited?: x Yes  No

If MRI Unit will be Accredited, is it  PENDING x ACCREDITED

If ACCREDITED, What Organization? ACR  
(Attach certificate or proof of accreditation.)

If no, why:

The MRI unit will be registered with the Health Facilities Commission.  Yes  No

**ESTABLISHING PET UNIT/SERVICE:** *(If more than one unit, use ATTACHMENT – A.)*

Physical Address of Service: \_\_\_\_\_

Name Brand of Unit \_\_\_\_\_

Type (i.e. PET Only, PET/CT, PET/MRI) \_\_\_\_\_

Unit's Serial Number \_\_\_\_\_

Will the PET Unit be Accredited?:  Yes  No

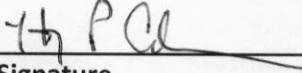
If PET Unit will be Accredited, is it  PENDING  ACCREDITED

If ACCREDITED, What Organization? \_\_\_\_\_  
(Attach certificate or proof of accreditation.)

If no, why:

The PET unit will be registered with the Health Facilities Commission.  Yes  No

Pursuant to Tennessee Rule of Civil Procedure 72, I hereby declare under perjury that the information provided in this application is true and correct. Signee for this application certifies that he or she is of responsible character and able to comply with the minimum standards and regulations established by Tennessee pertaining to the type of facility or services for which application for licensure is made and with the rules promulgated under Tennessee Code Annotated §68-11-201 and Rules 0720-.14, 0720-36, and 0720-47 adopted by the Commission effective December 1, 2025. Signee also certifies that a policy has been implemented to inform all employees of their obligation under TCA §71-6-103 to report incidents of abuse or neglect.

  
Signature

12/10/2025  
Date

CEO  
Title of Signee

Harry P Anderson II, Chip  
Printed Name

**Non-Refundable Licensing Fees for Listed Licensed Services**

An invoice will be sent to the contact for Billing for total payment of fees.

**MRI:**

Hospital: \$500 per MRI unit  
Outpatient Diagnostic Center: Included with ODC License  
Physician Office: \$500 per MRI unit

**PET:**

Hospital: \$500 per MRI unit  
Outpatient Diagnostic Center: Included with ODC License  
Physician Office: \$500 per MRI unit

*(as of December 1, 2025)*



**ATTACHMENT - B**

**INDIVIDUAL OWNERS INFORMATION**

Name	Address	City	State	ZIP
R Michael Cobb, MD	50 Capital Ave	Jackson	TN	38305
L David Johnson, MD	50 Capital Ave	Jackson	TN	38305
Kelly W Pucek, MD	50 Capital Ave	Jackson	TN	38305
David A Pearce, MD	50 Capital Ave	Jackson	TN	38305
Harold M Antwine, MD	50 Capital Ave	Jackson	TN	38305
Jason T Hutchison, MD	50 Capital Ave	Jackson	TN	38305
Adam M Smith, MD	50 Capital Ave	Jackson	TN	38305
J Douglas Halton, MD	50 Capital Ave	Jackson	TN	38305
Michael S Dolan, MD	50 Capital Ave	Jackson	TN	38305
Eric J Homberg, MD	50 Capital Ave	Jackson	TN	38305
W Stan Ragon, MD	50 Capital Ave	Jackson	TN	38305
Cameron D Knight, MD	50 Capital Ave	Jackson	TN	38305
David M Sickle, MD	50 Capital Ave	Jackson	TN	38305
Jace R Smith, MD	50 Capital Ave	Jackson	TN	38305
Nicholas A Vance, MD	50 Capital Ave	Jackson	TN	38305

AMERICAN COLLEGE OF RADIOLOGY®

# Certificate of Accreditation



## West TN Bone & Joint Institute

50 Capital Ave.  
Jackson, Tennessee 38305

was surveyed by the ACR® Committee on MRI  
Accreditation of the Commission on Quality and Safety

The following magnet was approved

**Philips Medical Systems Inc.  
Ingenua Ambition S 2024**

for

**MSK, Spine**

**Accredited from  
April 10, 2025 through December 23, 2026**

A stylized, cursive signature in black ink.

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Chair, Committee ON  
MRI Accreditation

A cursive signature in black ink that reads "David B. Fuson".

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Chair, Commission on  
Quality and Safety