



Certificate of Appointment for a Health Authority

The Health Authority has been appointed and approved by the:

(Put an "X" by the appropriate designation below)

☒ Commissioners Court for Fort Bend County

☐ Governing Body for the Municipality of _____

☐ Director, _____ Health Department

☐ Director, _____ Public Health District

I, _____, acting in my capacity
as: (Put an "X" by the appropriate designation below)

☐ County Judge or Designee

☐ Mayor or Designee

☐ Non-physician and the Local Health Department Director

☐ Non-physician and the Public Health District Director

do hereby certify the physician, Worsha Gale-Lowe, MD, who is licensed
by the Texas Board of Medical Examiners, was duly appointed as the (check as applicable),

☒ Health Authority

☐ Health Authority Designee

for the jurisdiction of Designee Fort Bend, Texas.

Date term of office begins October 31, 20 24

Date term of office ends November 1, 20 25, unless removed by law.

I certify to the above information on this the _____ day of _____, 20__.

Signature of Appointing Official



OATH OF OFFICE

For Health Authorities in the State of Texas

I, Letoshia Gale-Lowe, MD, do solemnly swear (or affirm), that I will faithfully execute the duties of the office of Health Authority (HA) of the State of Texas and will to the best of my ability, preserve, protect, and defend the Constitution and laws of the United States and of this State, so help me God.

Letoshia Gale-Lowe, MD

Affiant*

Dr. Gale-Lowe

Preferred Name (e.g. "J. Paul Doe")

5019 Betty Tice DR FORT BEND TX 77441

Mailing Address*

ZIP*

18624

Texas Medical License Number*

832-563-0081

Phone Number (Emergency/After Hours)*

No

Are you a deputy/backup HA?

letoshia.gale-lowe@fortbendcountytx.gov

Email Address (Official, if you have one)*

legalemd@gmail.com

Additional Email Address

SWORN TO and subscribed before me this _____ day of _____, 20__.

Signature of Person Administering Oath

Printed Name

Title

(Seal)

*=denotes required field



THE STATE OF TEXAS

Statement of Elected/Appointed Officer

(Please type or print legibly)

I Letasha Gale-Lowe, MD do solemnly swear (or affirm) that I have not directly or indirectly paid, offered, promised to pay, contributed, or promised to contribute any money or thing of value, or promised any public office or employment for the giving or withholding of a vote at the election at which I was elected or as a reward to secure my appointment or confirmation, whichever the case may be, so help me God.

A handwritten signature in black ink, appearing to read "Letasha Gale-Lowe, MD".

Affiant's Signature

Letasha Gale-Lowe, MD

Printed Name

Local Health Authority

Position to Which Elected/Appointed

Fort Bend County

City and/or County

SWORN TO and subscribed before me by affiant on this ____ day of _____ 20__.

Signature of Person Authorized to Administer
Oaths/Affidavits

Printed Name

Title

(Seal)