FORM H – Medical Physicists
Temporary Medical Physicists Supervisor Agreement
Texas Medical Board

APPLICANT: Complete the information in this box. You must have all members of the faculty of the Medical Physics Residency Program of the sponsoring institution OR all colleagues in the group practice sign the last page of this form.

Applicant's Current Full Name: _____ Name at time of affiliation if different: _____
Printed Printed

Applicant's Date of Birth: _____ Applicant TMB ID# _____

Applicant's Address: _____ Telephone: _____ E-Mail: _____

Application for: ☐ Licensed Medical Physicist ☐ Temporary Licensed Medical Physicist ☐ Provisional Medical Physicist

with the specialty(ies) in the area(s) indicated below:

☐ Diagnostic Radiological Physics (DRP) ☐ Therapeutic Radiological Physics (TRP)

☐ Medical Nuclear Physics (MNP) ☐ Medical Health Physics (MHP)

Name of Residency Program or Group Practice_____

Address _____

Beginning Supervision Date (mm/dd/yyyy) _____

Specialty Area for Supervision of Temporary Licensee:

☐ Diagnostic Radiological Physics (DRP) ☐ Therapeutic Radiological Physics (TRP)

☐ Medical Nuclear Physics (MNP) ☐ Medical Health Physics (MHP)

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), business or professional associates (past, present and future) and all governmental agencies (local, state, federal, or foreign) to release to the Texas Medical Board or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by the Board in connection with this application, necessary to determine my medical competence, professional conduct, or physical and/or mental ability to safely engage in the practice allowed under my license/certification. I further authorize the Texas Medical Board or its successors to release to the organizations, individuals, or groups listed above, any information, which is material to this application, or any subsequent licensure.

I authorize the release of the information contained in this evaluation form to the Texas Medical Board.

_____
Applicant's Signature

SUPERVISOR:

- The Medical Physicists rules require that a supervisor submit a supervision plan. The plan can be a page or less, and on your letterhead.
- The plan should explain which physics activities the temporary licensee will perform and how the supervision will occur. Please include a statement that all of his/her work will be checked and signed by you and that you will take responsibility for his/her work.
- After completing this form and supervision plan, place both in an envelope of the institution that you represent, seal the envelope, and place your signature over the outside sealed envelope flap.
- If you have any questions regarding how to complete this form, contact the Licensure Department at 512-305-7030.

FORM H – Medical Physicists

Applicant's Name_____ **Page 2**
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This is important: All information on this Form H, (including attachments that you provide as the Evaluating Professional) regarding a licensure applicant is confidential pursuant to §164.007(c) of the Medical Practice Act. **However, the Board must provide a copy of this Form H and attachments to an applicant when an application is referred to the Licensure Committee for licensure determination. Any information furnished by you is further subject to Chapter 160.010, of the Medical Practice Act, Immunity from Civil Liability.**

SUPERVISOR

1. Name: _____
2. License Number: _____
3. License Number Issue Date (mm/dd/yyyy): _____
4. License Number Expiration Date (mm/dd/yyyy): _____
5. Mailing Address: _____
   _____
6. Telephone Number: (_____) _____
7. Email Address: _____
8. Specialty Area for Supervision of Temporary Licensee:

   ☐ Diagnostic Radiological Physics (DRP) ☐ Therapeutic Radiological Physics (TRP)

   ☐ Medical Nuclear Physics (MNP) ☐ Medical Health Physics (MHP)

9. Beginning Supervision Date (mm/dd/yyyy): _____

SUPERVISION SETTING

1. Facility Name: _____
2. Mailing Address: _____
   _____
3. Telephone Number: (_____) _____
4. Fax Number: (_____) _____

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Applicant's Name_____ **Page 3**
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We, the undersigned, serve as: ☐ faculty members of the Medical Physics Residency Program at _____

☐ colleagues in the group practice of _____

Each of us is a Licensed Medical Physicists in the State of Texas and agrees to be delegated some or all of the duty to supervise TMP Applicant, who has applied for a temporary license to practice medical physics in Texas. Each of us is aware of the Rules of the Texas Medical Board and Texas Board of Licensure for Professional Medical Physicists and specifically of the requirement s that temporary licensees be supervised in their work by a licensed medical physicist in the appropriate specialty or specialties for that work and that the supervisor have the authority to correct their work. The supervisor must countersign the formal work products of the temporary licensee and take full responsibility for the work that he or she has supervised.

Name 1, MP#####, Program Director	Specialty Area	Date
Name 2, MP#####	Specialty Area	Date
Name 3, MP#####	Specialty Area	Date
Name 4, MP#####	Specialty Area	Date
Name 5, MP#####	Specialty Area	Date
Name 6, MP#####	Specialty Area	Date

THIS SECTION MUST BE SIGNED AND DATED BY THE SUPERVISOR AND TEMPORARY LICENSEE.

If the supervisory relationship changes, it is the *responsibility of the Supervisor* to IMMEDIATELY notify the Board in writing. IF for any reason the Supervisor does not notify the Board, then the Temporary Licensee must assume this responsibility.

I agree to follow and abide by the Medical Physics Practice Act and Board Rules.

_____ _____
Temporary Licensee's Signature Date

_____ _____
Supervisor's Signature Date

****Please notify the Board of any Name, Address, Telephone, or Supervision Changes Immediately*****

REMINDER: Supervisor - after completing this **form and supervision plan**, place both in an envelope of the facility that you represent, seal the envelope, and place your signature over the outside sealed envelope flap.

SEND TO: Texas Medical Board
MC-240
P.O. Box 2029
Austin, TX 78768-2029