FORM L
Physician Licensure Evaluation
Verification of Postgraduate Training and Professional Evaluation
Texas Medical Board

APPLICANT SECTION

APPLICANT:
Complete the information in this box. This form is to be returned to you in a sealed institution envelope with the evaluating physicians signature affixed over the outside envelope flap. You must have evaluations from every facility with which you have been affiliated in the past 5 years. Make additional copies of this form as needed.

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

Applicant's Date of Birth: _____

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

Name of Evaluating Hospital/Institution _____

Address of Evaluating Hospital/Institution _____

Dates of affiliation From (mm/yy) _____ To (mm/yy) _____

Department of Affiliation_____

Your position at the time of affiliation: ❑Intern ❑Resident ❑Fellow ❑Staff

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

_____
Applicant's Signature

EVALUATING PHYSICIAN SECTION

EVALUATING PHYSICIAN:

- A physician who currently holds one of the following positions must complete this evaluation: Chief of Staff, Training Director, Medical Director or Department Chairman. Letters of recommendation or standard institution verification forms will not be accepted in lieu of this form.
- After completing this evaluation, place this form in an envelope of the hospital/institution that you represented, 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 512-305-7130.

Evaluating Physician Name / Degree

_____

Title: ❑Chief of Staff
❑Department Chairman
❑Medical Director
❑Training Director

1. This evaluation is based on ❑ Personal Knowledge ❑ Review of Credential File

2. How long have you known the applicant? Years_____ Months _____

3. (a) Is the applicant related to you? ❑ Yes ❑ No
(b) Do you know the applicant well? ❑ Yes ❑ No
(c) Has your acquaintance with the applicant continued until recent date? ❑ Yes ❑ No

4. Do you consider the applicant:
(a) Reliable? ❑ Yes ❑ No
(b) Ethical? ❑ Yes ❑ No
(c) Of good character? ❑ Yes ❑ No

5. Please rate the applicant:

	EXCELLENT	GOOD	AVERAGE	ADEQUATE	POOR
(a) Professional ability					
(b) Attention to duties					
(c) Breadth of education					
(d) Interpersonal skills					

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Applicant's Name_____ **Page 2**

6. Has applicant, to your knowledge, ever been guilty of:

(a) Fraud or dishonesty? ❑ Yes ❑ No

(b) Unprofessional conduct? ❑ Yes ❑ No

7. If the English language is not the native language of this applicant, do you feel that he/she has the ability to adequately communicate in the English language? ❑ Yes ❑ No

8. To your knowledge, has the applicant ever:

(a) been warned, censured, disciplined, had admissions monitored or privileges limited? ❑ Yes ❑ No

(b) had disciplinary action taken against him/her by a licensing agency? ❑ Yes ❑ No

(c) been denied or surrendered a federal or state controlled substance permit? ❑ Yes ❑ No

(d) been arrested, fined, charged with or convicted of a crime, indicted, imprisoned or placed on probation? ❑ Yes ❑ No

(e) been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in his/her behalf or paid such a claim him/herself? ❑ Yes ❑ No

(f) been placed on probation, asked to withdraw or reprimanded? ❑ Yes ❑ No

9. If you answered "yes" to any of the above questions, please provide any additional information you may have, including the names of other individuals who may have information concerning this applicant.

_____

_____

_____

10. Are the dates of privileges provided by the applicant on the top portion of this form accurate? ❑ Yes ❑ No

11. If not, please provide the correct dates: Beginning month _____ / year ____Ending month _____ / year _____

VERIFICATION OF POST GRADUATE TRAINING

TRAINING PROGRAM DIRECTOR:
This section must be completed in addition to the sections above.

<table>
<tr>
<td rowspan="2">PROGRAM PARTICIPATION:

Report incomplete postgraduate years (PGY) separately from those that were successfully completed.

If the postgraduate year is currently in progress, report the expected completion date in the “To” field.

Report Internships, Residencies and Fellowships separately.
Use one section per department. If the department is rotating or transitional, please provide a schedule of rotations.</td>
<td>PGY: _____
___ Internship
___ Residency
___ Fellowship
___ Research</td>
<td>Department:
_____
From: ___/___/___ To: ___/___/___
Successfully completed?
☐ yes ☐ no ☐ in progress</td>
</tr>
<tr>
<td>PGY: _____
___ Internship
___ Residency
___ Fellowship
___ Research</td>
<td>Department:
_____
From: ___/___/___ To: ___/___/___
Successfully completed?
☐ yes ☐ no ☐ in progress</td>
</tr>
</table>

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UNUSUAL CIRCUMSTANCES: Circle the correct response. Omitted responses require written explanation. If necessary, you may continue your explanation on a separate sheet of paper.	1. Did this individual ever take a leave of absence or break from training? ❑ Yes ❑ No 2. Was this individual ever placed on probation? ❑ Yes ❑ No 3. Was this individual ever disciplined or placed under investigation? ❑ Yes ❑ No 4. Were any negative reports ever filed by instructors? ❑ Yes ❑ No 5. Were any limitations or special requirements placed upon this individual? because of questions or academic incompetence, disciplinary problems or any other reason? ❑ Yes ❑ No Please explain any "yes" response from above: _____ _____ _____

NOTE: All reports received by the TMB on a licensure applicant are confidential and are not subject to disclosure under the Texas Open Records Act; however, the board must disclose such reports if they are relied upon in a contested denial of licensure.

Evaluating Physicians Name: _____ (Printed) _____ (Signature)

Date: _____

Title: _____ Address: _____

Phone: _____ Fax: _____ E-mail: _____

Evaluating Physician's State of Licensure _____ Your License No.: _____

REMINDER: Evaluating Physician after completing this evaluation, place this form in an envelope of the hospital/institution that you represent, seal the envelope and place your signature over the outside sealed envelope flap.