FORM L

MRT, LMRT, NCT, RCP, and Perfusionist

Licensure Evaluation

Texas Medical Board

TO BE COMPLETED BY APPLICANT:
Complete the information in the Applicant box only. The remainder of the form should be completed and submitted by the employer as noted below. Applicant cannot upload this form in the LAMAS system. NOTE: Evaluator must be currently employed at facility.

Applicant's Current Full Name: _____
Printed

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

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

Name of Evaluating Hospital/Institution/Practitioner's Office _____

Address of Evaluating institution _____

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

Your position at the time of employment: _____

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 Date

TO BE COMPLETED BY EMPLOYER:

- This evaluation should be completed by one of the following at your facility: direct supervisor, licensed supervising practitioner, facility manager, credential specialist, or HR representative.
- The two page evaluation should be sent directly to the Texas Medical Board offices. See below for instructions.

This is important: All information on this Form L (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 L 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.**

INSTRUCTIONS FOR SUBMITING COMPLETED FORM:

1) By Mail – 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.

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

2) By Fax – Evaluator must submit the form along with an official hospital/institution coversheet to 888-550-7516. Fax submitted by the applicant and/or without the appropriate coversheet cannot be accepted.

3) By Email – Evaluator must submit the form from an official hospital/institution email address to screen-cic@tmb.state.tx.us. Emails sent from the applicant cannot be accepted. Only files attached as .pdf or .tif can be safely opened and drop boxes, secured emails, encrypted messages, or links to outside sites cannot be accepted.

4) Form Ls sent through the TMB LAMAS system will not be accepted.

FORM L

Applicant's Name_____ **Page 2**
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VERIFICATION OF PROFESSIONAL HISTORY

1. This evaluation is based on □ Personal Knowledge □ Review of Personnel File

2. Applicant's Title or Position: _____

3. Provide dates of affiliation: **Beginning** month _____ / year _____ **Ending** month _____ / year _____

4. Employment Status: □ Full-Time

□Part-time _____ Hours worked weekly

5. Is the applicant related to you? □ Yes □ No

6. To your knowledge, has the applicant ever:

(a) been investigated by your facility? □ Yes □ No

(b) been disciplined by your facility? □ Yes □ No

(c) had practice related concerns? □ Yes □ No

(d) had patient safety issues? □ Yes □ No

7. If you answered "yes" to any of the above question #6, please explain below and provide copies of any related documentation you may have, including the names and contact information of other individuals who may have information concerning this applicant.

_____

_____

_____

Evaluator's name: _____ **Title:** _____
Printed

Evaluating Practitioner's License Number, License Type, and State of Licensure (if applicable):

_____

Institution/Facility Name: _____

Address: _____

Phone: _____ **E-Mail**: _____

Signature: _____ **Date:** _____