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

APPLICANT:
Complete the information in this box. You must have evaluations from every facility with which you have been affiliated in the past 5 years. Note – your licensure analyst may require additional evaluations outside the past 5 years.

Applicant's Current Full Name: _____
Printed

Applicant TMB ID# _____

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 ☐ Faculty ☐ Staff ☐ Other: _____

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 of medicine. 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

EVALUATING PHYSICIAN:

- A physician who currently holds one of the following positions must complete this evaluation: Chief of Staff, Department Chairman, Medical Director, or Training Director. Letters of recommendation or standard institution verification forms will not be accepted in lieu of this form.
- This completed evaluation should be sent directly to the Texas Medical Board offices via mail, fax, or email.
  - 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
  - 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.
  - By email - Evaluator must submit the form from an official practice/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.

This is important: All information on this Form L, (including attachments that you provide as the Evaluating Physician) 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.**

FOR TRAINING POSITIONS – Completion of the Verification of Post Graduate Training on page 2 and the Verification of Professional History on page 3 are required.

FOR NON-TRAINING POSITIONS – Only completion of the Verification of Professional History on page 3 is required.

FORM L

Applicant's Name____

Printed

VERIFICATION OF POST GRADUATE TRAINING Only post-graduate training completed at this institution should be evaluated in this section.		
POST GRADUATE TRAINING 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.	**PGY:** _______ ___ Internship ___ Residency ___ Fellowship ___ Research	Department: ________________________________ From: ___/___/___ To: ___/___/___ Credit received? ☐ Full ☐ *Partial ☐ in progress *For partial credit– how many months?______
	PGY: _______ ___ Internship ___ Residency ___ Fellowship ___ Research	Department: ________________________________ From: ___/___/___ To: ___/___/___ Credit received? ☐ Full ☐ *Partial ☐ in progress *For partial credit– how many months?______
	PGY: _______ ___ Internship ___ Residency ___ Fellowship ___ Research	Department: ________________________________ From: ___/___/___ To: ___/___/___ Credit received? ☐ Full ☐ *Partial ☐ in progress *For partial credit– how many months?______
	PGY: _______ ___ Internship ___ Residency ___ Fellowship ___ Research	Department: ________________________________ From: ___/___/___ To: ___/___/___ Credit received? ☐ Full ☐ *Partial ☐ in progress *For partial credit– how many months?______

UNUSUAL CIRCUMSTANCES: (For training positions only)	☐ Yes ☐ No 1. Did this individual ever take a leave of absence or break from training? ☐ Yes ☐ No 2. Did this individual resign from training? ☐ Yes ☐ No 3. Were any limitations or special requirements placed upon this individual for professionalism or behavioral issues? ☐ Yes ☐ No 4. Did this individual ever receive a written warning or documented counseling about his/her behavior? ☐ Yes ☐ No 5. Was this individual ever placed on probation for any reason? ☐ Yes ☐ No 6. Is this individual currently under investigation? ☐ Yes ☐ No 7. Were this individual's privileges or duties ever reduced, suspended, or revoked? ☐ Yes ☐ No 8. Did this individual experience delayed promotion or delayed advancement to the next level? ☐ Yes ☐ No 9. Was this individual informed his/her contract would not be renewed? ☐ Yes ☐ No 10. Was this individual suspended, terminated, or dismissed from training? If you answered "yes" to any of the above questions, please provide any additional information you may have. ____ ____ ____

FORM L

Applicant's Name_____

VERIFICATION OF PROFESSIONAL HISTORY

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

2. Is this applicant related to you? ☐ Yes ☐ No

3. Do you consider the applicant:

(a) Reliable?	☐ Yes	☐ No
(b) Ethical?	☐ Yes	☐ No
(c) Of good character?	☐ Yes	☐ No

4. Please rate the applicant:

	Excellent	Good	Average	Poor
(a) Professional ability				
(b) Attention to duties				
(c) Breadth of education				
(d) Interpersonal skills				

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

(a) Fraud or dishonesty?	☐ Yes	☐ No
(b) Unprofessional conduct?	☐ Yes	☐ No

6. To your knowledge, has the applicant ever:

(a) been warned, censured, reprimanded, disciplined, had admissions monitored or privileges limited or suspended?	☐ 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
(g) been terminated, resigned in lieu of termination or during investigation?	☐ Yes	☐ No

If you answered "yes" to any of Question 5 and/or 6, please provide any additional information you may have, including the names of other individuals who may have information concerning this applicant.

_____

_____

_____

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

Evaluating Physician's Name/Degree: _____

Title: ☐ Chief of Staff ☐ Department Chair ☐ Medical Director ☐ Training Director

Phone: _____ **Fax:** _____

Address: _____

Email Address: _____

Signature: _____ **Date:** _____