

Form L - PA
Physician Assistant Licensure Evaluation
Texas Physician Assistant Board

APPLICANT:

Complete the information in this box. Evaluations are required to be sent 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: _____ Name at time of affiliation if different: _____
Printed Printed

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

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

Name of Supervising Physician's Hospital/Institution _____

Address of Supervising Physician's Hospital/Institution _____

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

Department of Affiliation _____

Your position at the time of affiliation: ☐ Student ☐ Faculty ☐ Staff

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 PROFESSIONAL:

- A supervising physician, or for new graduates, Program Director, must complete this evaluation. 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. See below for instructions.
- If you have any questions regarding how to complete this form contact the Licensure Department at 512-305-7030.

**Evaluating
Professional's
Name/Degree:**

Printed

Title: ☐ Supervising Physician
☐ Program Director

Title: _____

Phone: _____ Address: _____

Fax: _____ E-Mail: _____

Evaluating Professional's License Number and
State of Licensure _____

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Applicant's Name _____

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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.**

Program Directors – Please fill out this box in addition to the rest of the form

UNUSUAL CIRCUMSTANCES IN PA SCHOOL:

Please attach an explanation for any "yes" response.

- | | |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 1. Did this individual ever take a leave of absence or break from training? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 2. Did this individual resign from training? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 3. Were any limitations or special requirements placed upon this individual for professionalism or behavioral issues? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 4. Did this individual ever receive a written warning or documented counseling about his/her behavior? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 5. Was this individual ever placed on probation for any reason? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 6. Is this individual currently under investigation? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 7. Were this individual's privileges or duties ever reduced, suspended, or revoked? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 8. Did this individual experience delayed promotion or delayed advancement to the next level? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 9. Was this individual suspended, terminated, or dismissed from training? |

VERIFICATION OF PROFESSIONAL HISTORY

- This evaluation is based on ☐ Personal Knowledge ☐ Review of Credential File
- How long have you known the applicant? Years _____ Months _____
- Is the applicant related to you? ☐ Yes ☐ No
- Do you know the applicant well? ☐ Yes ☐ No
- Has your acquaintance with the applicant continued until recent date? ☐ Yes ☐ No
- Do you consider the applicant:

(a) Reliable?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(b) Ethical?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(c) Of good character?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

7. Please rate the applicant:

- Professional ability
- Attention to duties
- Breadth of education
- Interpersonal skills

Excellent	Good	Average	Poor

- Has applicant, to your knowledge, ever been guilty of:

(a) Fraud or dishonesty?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(b) Unprofessional conduct?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
- To your knowledge, has the applicant ever:

(a) been warned, censured, reprimanded, disciplined, had admissions monitored or privileges limited or suspended?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(b) had disciplinary action taken against him/her by a licensing agency?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(c) been denied or surrendered a federal or state controlled substance permit?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(d) been arrested, fined, charged with or convicted of a crime, indicted, imprisoned or placed on probation?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(f) been placed on probation, asked to withdraw, or reprimanded?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(g) been terminated, resigned in lieu of termination or during investigation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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If you answered "yes" to any of the questions under #8 or #9, 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 affiliation 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 ____

Evaluating Professional's Name: _____
Printed Signature

Date: _____

INSTRUCTIONS FOR SUBMITTING 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 888-790-0621. 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 or from a non-agency email address cannot be accepted.