Performance Evaluation/ Surgical Assistant
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 evaluator as noted below. Applicants cannot submit this form.

Applicant's Current Full Name: _____
Printed

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

Name of Evaluating Physician _____

Address of Evaluating institution _____

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

_____ _____
Applicant's Signature Date

EVALUATING PHYSICIAN:
- You must be licensed in the United States as either a Doctor of Medicine or Doctor of Osteopathic Medicine.
- You must have supervised the applicant working as a surgical assistant for a period in the past three (3) years.
- Letters of recommendation are not accepted in lieu of this form.
- This completed 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.

VERIFICATION OF PROFESSIONAL HISTORY

1. How long have you known the applicant? _____ Years _____ Months

2. In the past three (3) years preceding the completion date of this form, how many hours has the applicant worked under your direct supervision as a surgical assistant? _____ Hours

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

4. Is the applicant related to you? ☐ Yes ☐ No

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

6. Has the 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 they have 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 arrested, fined, charged with or convicted of a crime, indicted, imprisoned or placed on probation? ☐ Yes ☐ No
(d) been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid on their behalf or paid such a claim themselves? ☐ Yes ☐ No
(e) been placed on probation, asked to withdraw or reprimanded? ☐ Yes ☐ No

9. Please rate the applicant:

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

10. If you answered "yes" to any of the previous questions in #6 and #8 of this form, please provide any additional information you may have, including the names of other individuals who may have information concerning this applicant.

_____

_____

Evaluating Physician's name: _____ **Title:** _____
Printed

Evaluating Physician's License Number and State of Licensure: _____

Institution/Facility Name: _____

Address: _____

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

Signature: _____ **Date:** _____