TEXAS MEDICAL BOARD

EMERGENCY VISITING PRACTITIONER TEMPORARY PERMIT

Texas Sponsoring Physician Information

Name: _____
(As imprinted on Texas medical license)

Email Address: _____

Telephone Number: _____ Fax Number: _____

Physical Address:_____

For Texas licensed telemedicine provider sponsoring out-of-state telemedicine physicians provide:

Telemedicine Employer:_____

Visiting Practitioner's Information

On a separate sheet, please provide the following information for each Out-of-State Physician that will be providing healthcare services under the Emergency Visiting Practitioner Temporary Permit as part of disaster relief efforts.

Name of Physician:

Social Security #:

DOB:

Date of Graduation (mm/dd/yy):

Degree type: MD or DO

Texas Sponsoring Physician's Signature:

I affirm that I will be the supervisor/sponsor for all reported Out-of-State Physicians that have agreed to provide healthcare services under the Emergency Visiting Practitioner Temporary Permit as part of disaster relief efforts.

_____ _____

Applicant's Signature Date

Emergency Visiting Practitioner Temporary Permit is valid for no more than thirty (30) days from the date the physician is licensed or until the emergency or disaster declaration has been withdrawn or ended, whichever is longer.

Location Address:
333 Guadalupe, Tower 3, Suite 610
Austin, Texas 78701

Mailing Address
P.O. Box 2029
Austin, Texas 78768-2029

Phone 512.305.7030
Fax 512.463-9416
Licensure Fax 512.305.7009
www.tmb.state.tx.us