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

APPLICANT:
Complete the information in this box. You must have evaluations from every supervising physician 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) Name at time of affiliation if different: _____ (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.

Title: ☐ Supervising Physician ☐ Program Director

Evaluating Professional's Name/Degree: _____ (Printed)

Title: _____

Phone: _____ Address: _____

Fax: _____ E-Mail: _____

Evaluating Professional's License Number and State of Licensure _____

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Applicant's Name_____ **Page 2**
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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 <u>in addition to</u> the rest of the form

UNUSUAL CIRCUMSTANCES IN PA SCHOOL:

Please attach an explanation for any "yes" response.

□ 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 suspended, terminated, or dismissed from training?

VERIFICATION OF PROFESSIONAL HISTORY

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

2. How long have you known the applicant? Years_____ Months _____

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

4. Do you know the applicant well? □ Yes □ No

5. Has your acquaintance with the applicant continued until recent date? □ Yes □ No

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

7. Please rate the applicant:

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

8. Has applicant, to your knowledge, ever been guilty of:
(a) Fraud or dishonesty? □ Yes □ No
(b) Unprofessional conduct? □ Yes □ No

9. 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

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Applicant's Name_____ **Page 3**
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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 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 888-790-0621. 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.