ACUPUNCTURE LICENSURE – REFERRAL ATTESTATION

Professional Evaluation

Texas State Board of Acupuncture Examiners

IMPORTANT:
This form is to be completed by applicants that are in solo practice. This form should be completed by three (3) separate licensed acupuncturists in the U.S. who the applicant either refers patients to, who the applicant receives referrals from, or who are familiar with the applicant's clinical practice during the five years prior to submission of an application. Make copies of this form as needed.

TO BE COMPLETED BY APPLICANT:
Complete the information in this box only and have the evaluating acupuncturists complete the remainder of the form and submit to the TMB directly. **Please send an email to Screen-CIC@tmb.state.tx.us naming the three acupuncturists who will be completing this form on your behalf to help facilitate the updating of your application.**

Applicant's Current Full Name: _____
Printed

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

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

Name of Evaluating Acupuncturist: _____

Practice Address of Evaluating Acupuncturist: _____

Email address of Evaluating Acupuncturist: _____

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

_____
Applicant's Signature

TO BE COMPLETED BY EVALUATING ACUPUNCTURIST:
This evaluation should be completed by an acupuncturist who has a referring and/or professional relationship with the applicant named above. This completed evaluation should be sent directly to the Texas Medical Board offices. See below for instructions to submit the completed form.

Evaluating Acupuncturist's Name/ Degree: _____

Evaluating Acupuncturist's License Number/State of Licensure: _____

Practice Address:

_____

_____
(City) (State) (Zip Code)

Telephone: _____ E-Mail: _____

INSTRUCTIONS FOR SUBMITING COMPLETED FORM:

1) By mail - Place this form in an envelope of the practice/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 practice/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 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.

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Applicant's Name_____ **Page 2**
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VERIFICATION OF PROFESSIONAL HISTORY

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

2. Describe your professional relationship with the applicant:

_____

_____

_____

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

4. Do you refer patients to this applicant? ☐ Yes ☐ No

If yes, approximately how many patients do you refer to this applicant per month? _____

5. Does the applicant refer patients to you? ☐ Yes ☐ No

If yes, approximately how many patients are referred to you per month? _____

6. To your knowledge, has the applicant ever:

☐ Yes ☐ No (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?

If you answered "yes" to any of the above questions, please provide any additional information you may have, including the names and contact information of other individuals who may have information concerning this applicant.

_____

_____

_____

ATTESTATION: The information provided on this form is accurate to the best of my knowledge.

_____
Evaluating Acupuncturist's Printed Name

_____
Evaluating Acupuncturist's Signature

_____
Date