FORM L

Physician Licensure Evaluation – Texas Medical Board Verification of Postgraduate Training and Professional Evaluation

APPLICANT: Complete the information in this box. You mup past 5 years. Note – your licensure analyst management of the second of				ne
Applicant's Current Full Name:			-	
Printed	Name at un	ie or aniliation ii un	Printed	-
Applicant's Date of Birth:	Applicant T	MB ID#		
Applicant's Address:	Telephone:		E-Mail:	
Name of Evaluating Hospital/Institution				
Address of Evaluating Hospital/Institution				
Dates of affiliation From (mm/yy)	To (mm/yy)			
Department of Affiliation				
Your position at the time of affiliation:	□ Intern □ Residen	t 🗆 Fellow 🗆 F	Faculty Staff	
I hereby authorize all hospitals, institutions of future), business or professional associates foreign) to release to the Texas Medical Boeducational records, and records of psychiatr by the Board in connection with this application, application, or any subsequent licensure.	(past, present and futu- ard or its successors a ric treatment and treatmation, necessary to detage in the practice of m	ire) and all governing information, file ent for drug and/or termine my medicatedicine. I further a	mental agencies (local, state, federa s or records, including medical reco alcohol abuse or dependency, reque al competence, professional conduc uthorize the Texas Medical Board of	al, or ords, ested or, or its
I authorize the release of the information	contained in this evalu	uation form to the	Texas Medical Board.	
Applicant's Signature				
A physician who currently holds one of the Chairman, Medical Director, or Training Deaccepted in lieu of this form. This completed evaluation should be sent of By mail - Place this form in an envesignature over the outside sealed en 78768-2029 By fax - Evaluator must submit the submitted by the applicant and/or well By email - Evaluator must submit the screen-cic@tmb.state.tx.us. Emails	director. Letters of reconding the lope of the hospital/inst nivelope flap. Send to: Torm along with an official thout the appropriate ce form from an official h	dical Board offices itution that you represent the seas Medical Board all hospital/institution expersed to the seas Medical Board hospital/institution expersed to the seas Medical Pinstitution expersed to the season of the sea	dard institution verification forms will via mail, fax, or email. resent, seal the envelope and place d, MC-240, P.O. Box 2029, Austin, on coversheet to 888-790-0621. Fax the accepted.	your TX
		Title:	□ Chief of Staff	
Evaluating Physician's Name/Degree:			 Department Chairman Medical Director Training Director 	
	Printed		= 1.4g 200.0.	
Title:				
Phone:	Address:			
Fax:	E-Mail:			
Evaluating Physician's License Number and State of Licensure				

FORM L

Applicant's Name_			
•	Printed	_	

This is important: All information on this Form L, (including attachments that you provide as the Evaluating Physician) 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.

FOR TRAINING POSITIONS – Completion of the Verification of Post Graduate Training <u>and</u> the Verification of Professional History sections are required.

FOR NON-TRAINING POSITIONS - Only completion of the Verification of Professional History section is required.

	jerriente em jeer	inplotion of the vermoe	ation of Frolessional History section is required.		
VERIFICATION OF					
This section relates to skip to the Verification			t complete postgraduate training at this institution please		
			Department:		
PROGRAM PARTICIPATION: (For training positions only)		PGY: Internship			
Report <i>incomplete</i> postgraduate years		Residency	From://_ To://		
(PGY) separately from successfully complete	those that were	Fellowship Research	Credit received? ☐ Full ☐ *Partial ☐ in progress		
If the postgraduate year			*For partial credit— how many months?		
progress, report the ex			Department:		
date in the "To" field.		PGY:			
Report Internships, Re Fellowships separately		Internship Residency	From:// To://		
per department.		Fellowship	Credit received?		
		Research	Full *Partial in progress		
			*For partial credit– how many months?		
			Department:		
		PGY: Internship	From:// To://		
		Residency	Credit received?		
		Fellowship Research	Full *Partial in progress		
			*For partial credit– how many months?		
UNUSUAL CIRCUMSTANCES: (For training positions only) Please attach an explanation for any "yes" response.	□ Yes □ No 2. □ Yes □ No 3. □ Yes □ No 4. □ Yes □ No 5. □ Yes □ No 6. □ Yes □ No 8. □ Yes □ No 9.	Did this individual ever take a leave of absence or break from training? Did this individual resign from training? Were any limitations or special requirements placed upon this individual for professionalism or behavioral issues? Did this individual ever receive a written warning or documented counseling about his/her behavior? Was this individual ever placed on probation for any reason? Is this individual currently under investigation? Were this individual's privileges or duties ever reduced, suspended, or revoked? Did this individual experience delayed promotion or delayed advancement to the next level? Was this individual informed his/her contract would not be renewed? Was this individual suspended, terminated, or dismissed from training?			

FORM L

pplicant's Name	WONAL HIGTORY				Р	age 3
1. This evaluation is based on		Review of Creden	tial Fila			
2. How long have you known the	_					
 Is the applicant related to you' 		Months	— □ Yes	□ No		
4. Do you know the applicant we			□ Yes	□ No		
5. Has your acquaintance with the		ent 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:						
(a) Professional ability	Excellent G	Good A	verage	Poo	r	
(b) Attention to duties						
(c) Breadth of education(d) Interpersonal skills						
8. Has applicant, to your knowledge	e, ever been quilty of:	1		1		
(a) Fraud or dishonesty? (b) Unprofessional conduct?	s, ever been gamy en				□ Yes □ Yes	□ No □ No
9. To your knowledge, has the app		ningiana manitarad	or privilege	a limitad		
(a) been warned, censured, rep or suspended?	mmanded, disciplined, nad adn	nissions monitorea	or privilege		□ Yes	□ No
(b) had disciplinary action taken(c) been denied or surrendered					□ Yes	□ No
(d) been arrested, fined, charge			d		□ Yes	□ No
or placed on probation?	action involving professional lie	shility (malarastics)	or had a		□ 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?(g) been terminated, resigned in lieu of termination or during investigation?					□ Yes □ Yes	□ No □ No
(g) been terminated, resigned in	r lieu or termination or during if	ivestigation?			□ 1 <i>e</i> s	
If you answered "yes" to any of the names of other individuals w				ion you may	[,] have, ir	ncluding
10. Are the dates of privileges prov	rided by the applicant on the to	p portion of this for	m accurate	?	□ Yes	□ No
11. If not, please provide the correct	ct dates: Beginning month	/ yearEndi	ng month _	/ year	r	_
Evaluating Physicians Nam						
	Print	ted		Sign	ature	
Date:						