PHYSICIAN LICENSURE – REFERRAL ATTESTATION

Professional Evaluation
Texas Medical Board

IMPORTANT:
This form is to be completed by applicants that are in solo practice ONLY and have not held hospital affiliations for any period of time within the five years prior to submission of their application. This form should be completed by three (3) separate licensed physicians in the U.S. who the applicant either refers patients to, or who the applicant receives referrals from. Please note that colleagues without a referring relationship to the applicant cannot complete this form. Make copies of this form as needed.

TO BE COMPLETED BY APPLICANT:
Complete the information in this box only and have the evaluating physicians complete the remainder of the form and submit to the TMB directly. **Please submit a LIST message to the TMB naming the three physicians 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 Physician/ Degree: _____

Practice Address of Evaluating Physician: _____

Email address of Evaluating Physician: _____

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

TO BE COMPLETED BY EVALUATING PHYSICIAN:
This evaluation should be completed by a physician who has a referring 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 Physician's Name/ Degree: _____

Evaluating Physician's Specialty: _____

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

Practice Address:

_____

_____
(City) (State) (Zip Code)

Telephone: _____ **E-Mail:** _____

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Applicant's Name_____ **Page 2**
Printed

VERIFICATION OF PROFESSIONAL HISTORY

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

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

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

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

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

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

5. 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 question #5, 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 Physician's Printed Name/Degree

_____
Evaluating Physician's 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 888-550-7516. 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.