TEXAS MEDICAL BOARD

VISITING PHYSICIAN TEMPORARY PERMIT APPLICATION

(Applicants should allow 30 days for processing of a Visiting Physician Temporary Permit)

PLEASE TYPE OR PRINT CLEARLY

Visiting Physician's Information

Name: _____MD / DO_____

Email Address: _____

Social Security #:_____

DOB:_____ Place of Birth (State/Province/Country):_____

Medical School of Graduation: _____

Date of Medical School Graduation (mm/dd/yy):_____

Medical License Number(s) and State(s) held:

_____

Texas Sponsoring Physician Information

Name _____ Texas license number:_____

(As imprinted on Texas medical license)

Email Address: _____

Point of Contact for this Application (this will be the individual TMB staff will contact for additional information, if necessary)

Name: _____

Email Address: _____

Telephone Number: _____

Procedure Information

Date(s) of procedure (10 days or less): _____

Location of procedure/event - Hospital/Facility Name _____

Location of procedure/event - Complete Address: _____

_____TX, _____

Name of proposed procedure/event: _____

Brief explanation of procedure/purpose for visit:_____

_____

Location Address:
1800 Congress Ave, Suite 9-200
Austin, Texas 78701

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

Phone 512.305.7030
Licensure Fax 888.550.7516
www.tmb.state.tx.us

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TEXAS SPONSORING PHYSICIAN ATTESTATION

Note: If multiple sponsoring physicians are to be considered, please have each sponsoring physician complete the attestation.

I, _____, with Active and Unrestricted Texas medical license

number _____ , attest to the following:

☐ I will provide continuous supervision of applicant: _____.
Applicant Name

☐ I understand that I do not need to be on-site with the applicant during their stay, but I will need to be available, should the need arise.

☐ Date of proposed procedure or event: _____to _____.
MM/DD/YYYY MM/DD/YYYY

Note: A VPTP is valid for ten working days, unless otherwise approved by the Executive Director.

☐ Facility where the proposed procedure or event will be held:

_____
Facility Name City

☐ I understand that if I have been the subject of a disciplinary order with the Texas Medical Board in the past (regardless of reason) that I am ineligible to supervise the applicant.

_____
Texas Sponsoring Physician Name (Print)

_____ _____
Texas Sponsoring Physician Signature Date

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