

Text Facsimile of Online Physician Licensure Application

Login

Physician Licensure Application

- Information you enter will be automatically be saved at the end of every page.
- You must complete the application within 15 days or your information will be deleted.
- Some of the questions may direct you to download a supplemental form and submit it, along with any relevant records.
- Pay the license fee using one of the following:
 - MasterCard,
 - Visa,
 - Discover,
 - American Express, or
 - Electronic Check.

Do you need to renew a current license?

Go to <http://www.tmb.state.tx.us/page/renewal-physician-online-registration-registration>. If you are unable to log in, please contact Board Offices at (512) 305-7030 for renewal information.

[Check Your Eligibility](#)

[FAQ](#)

Processing times can vary depending on the acceptability of submitted items and the complexity of your application. Some of the factors that can increase complexity are “yes” answers to the professionalism questions on this application.

Enter to create a new application or to return to a saved application.

Asterisk (*) indicates response required.

Email*:

Date of Birth (MM/DD/YYYY)*:

Continue

Identification

Asterisk (*) indicates response required.

For JP first and last name, provide your name as it is listed on either your current driver license, issued by a state driver license bureau in the United States, or your current passport. We will furnish this information to the testing center that administers the jurisprudence exam (JP). Your name must match exactly when you present your identification at the testing center, or you will not be allowed to take the exam.

JP First Name*

JP Last Name*

Full Name as you wish it to appear on your receipt*:

Your name, as entered in the next 4 fields, will be the name that appears on your license and your physician profile on the web site.

Applicant First Name*:

Applicant Middle Name:

Applicant Last Name*:

Suffix:

Social Security Number (XXX-XX-XXXX or XXXXXXXXX)*:

Alternate Names:

Application Type*:

Federation Credentials Verification Service* Using FCVS?

- ☐ Yes
- ☐ No

Expediting Factors

Applicants who agree to treat Medicare and Medicaid patients, practice in a medically underserved area, a health professional shortage area, or a rural area may be eligible for expedited handling. In addition, if you are a military service member, or the spouse of a military service member, assigned to a unit headquartered in Texas, your application may be eligible for expedited handling.

If you would like to request that your application be expedited, please select all that apply:

- ☐ Medicaid/Medicare
- ☐ Medically Underserved Areas
- ☐ Health Professional Shortage Areas
- ☐ Rural Areas
- ☐ Military Service Member (active duty)
- ☐ Spouse of a Military Service Member (active duty)

Initial information will be sent to you at this email address once your application is received in our office. If this is not the email address you want to use, create a new log in with the correct email address. You will receive instructions to access our online messaging system at this email within 2 business days of application submission.

Email Address:

Gender*:

- ☐ Male
- ☐ Female

Country of Birth*:

If you were born in the United States, please select your state of birth:

US State of Birth:

Date of Birth (MM/DD/YYYY)*:

Race*:

Are you of Hispanic Origin*:

- ☐ Yes
- ☐ No

If you are a Texas high school graduate, please provide the county where your high school is located:

Texas High School County:

Please provide the city in which you plan to practice.

Texas Planned Practice location - City

Self-Designated Specialty

Select your specialty from the drop down list. If you are unable to locate your specialty on the list, please select "Other Specialty".

Primary Specialty*:

Secondary Specialty:

Continue

Address

Please provide your current mailing address and **daytime** U.S. phone number. **It is your responsibility to notify the Board in writing if you have a change of address.**

All correspondence will be sent to the mailing address. When entering a foreign address leave the State blank and provide a Country.

Asterisk (*) indicates response required.

Mailing address

Mailing Address 1*:

Mailing Address 2:

City*:

State:

Postal/ZIP Code*:

Province:

Country*:

Telephone Number ###-###-####*:

Training and Work History

- List all U.S. or Canadian post-graduate training since graduation from medical school.
- List all professional affiliations for the past 5 years. Include hospitals, clinics, military assignments, government agencies, and locum tenens assignments.
- If you are a solo practitioner and you have not held any level of hospital affiliations in the past 5 years, you must provide information about your referral sources to be used in your evaluation. Select Solo Practice as the “Position” and use the Facility/Employer fields for the addresses of your referral sources. In the “Department” field, enter the city and state of your practice.
- List all periods of unemployment or employment outside the field of medicine. For periods of unemployment, use your home address.
- To indicate a current position, enter today’s date as an end date.
- You must send [our evaluation form](#) (Form L) to each facility listed, including training programs and professional affiliations.
- If a facility is no longer operating, please submit [Form Q](#).

Add Training and Work History

Asterisk (*) indicates response required.

| | |
|--|----------------------|
| Position*: | <input type="text"/> |
| Department*: | <input type="text"/> |
| Start Date (MM/YYYY)*: | <input type="text"/> |
| End Date (MM/YYYY)*: | <input type="text"/> |
| Facility/Employer Name*: | <input type="text"/> |
| Facility/Employer Street*: | <input type="text"/> |
| Facility/Employer City*: | <input type="text"/> |
| Facility/Employer State: | <input type="text"/> |
| Facility/Employer ZIP/Postal Code*: | <input type="text"/> |
| Facility/Employer Province: | <input type="text"/> |
| Facility/Employer Country*: | <input type="text"/> |
| Facility/Employer Phone Number (###-###-####): | <input type="text"/> |

Continue

Professional History

Attention: This is important. Be sure to disclose all relevant disciplinary actions, charges, or convictions. A false response to any of these questions may be grounds for disciplinary action, or even denial of licensure. Avoid some of the common excuses heard from people who fail to disclose, such as:

- My attorney told me I didn't have to disclose the criminal conduct or disciplinary actions.
- I didn't think the prior conduct had anything to do with the profession.
- I didn't think the disciplinary action, arrest, charges, or conviction was still on my record.
- I didn't think it was subject to disclosure because I received a deferred sentence/judgment.
- My program director/faculty advisor said it wouldn't appear on my report.

All supplemental forms listed can be found on the [Additional Forms](#) section of our website.

Asterisk (*) indicates response required

Question 1

Have you ever been issued a Texas Medical license? *

If you answered "Yes" to the question above, record your Texas license number (ex. A1234)

Texas License number:

Question 2

Have you ever been issued any other permit/license to train or practice in Texas? (examples – Institutional Permit, Physician in Training Permit, Visiting Professor Permit or Faculty Temporary License?*

Question 3

List all states in which you have applied for or have been granted licensure or certification as any type of healthcare provider. Choose a type of license and state from the drop down lists below. If you are unable to locate your license type, please use "Unassigned", and be aware that this will delay the processing of your application. Use [Form AA](#) if you have more than five licenses.

Type of License

State

Arrest/Criminal History

This is important: The board will run queries with the Texas Department of Public Safety (and the FBI) to verify your criminal history. Both entities maintain records, often beyond the time that courts keep them. Please be aware that if you have **ever** been arrested, charged, or convicted of a misdemeanor or a felony, the record of those events will be reported as a result of the fingerprint inquiry.

Serious traffic offenses such as reckless driving, driving under the influence of alcohol and/or drugs, hit and run, evading a peace officer, failure to appear, driving while the license is suspended or revoked **MUST** be reported. This list is not all-inclusive. If in doubt as to whether an offense should be disclosed, it is better to disclose the offense on the application.

Matters in which you were diverted, deferred, pardoned, or pled nolo contendere **MUST be disclosed.**

If you believe your offense was **sealed or expunged**, you **must** be able to provide a copy of the expunction or non-disclosure order if requested.

If you are in doubt as to how to respond to the questions, full and honest disclosure is highly recommended.

If you answer "Yes" to any question in this section, you are required to submit records and a statement. See [Form R](#).

Question 4*

Have you ever been arrested?

Question 5*

Have you ever been charged with any violation of the law regardless of outcome? (Unless the offense involved alcohol or drugs, you may exclude: 1) traffic tickets; and, 2) violations with fines of \$250 or less).

Question 6*

Are you currently the subject of a grand jury or criminal investigation?

Question 7*

Have you ever been placed on probation?

Question 8*

Have you ever been granted deferred adjudication or any other type of pretrial diversion? (Unless the offense involved alcohol or drugs, you may exclude: 1) traffic tickets; and, 2) violations with fines of \$250 or less.)

Question 9*

Have you ever been convicted of an offense or imprisoned?

Including the incidents you reported in Questions 4-9 above, have you been convicted of, or received deferred adjudication for, a felony, a Class A or Class B misdemeanor for a violation relating to:

(required – see Tex. Occ. Code, Sec. 156.001(e)). If you answer “Yes”, submit [Form R](#).

Question 9a*

Medicaid, Medicare or Insurance fraud

Question 9b*

the Texas Controlled Substances Act or intoxication or alcohol beverage offenses

Question 9c*

sexual or assaultive offenses

Question 9d*

tax fraud or evasion

Actions by Health Professional Licensing or Certification Authorities

(Including but not limited to licensing and/or regulatory agencies, specialty boards, and licensing exam administration authorities)

If you answer “Yes” to any question in this section, you are required to submit records and a statement. See [Form S](#).

Question 10*

Have you ever withdrawn an application for a license, permit or certification as a healthcare professional?

Question 11*

Have you ever been determined ineligible for a license, permit or certification as a healthcare professional?

Question 12*

Are you currently the subject of an investigation by any health professional licensing or certification authority?

Question 13*

Have you ever had limitations, conditions, or restrictions placed on a healthcare professional license?

Question 14*

Have you ever been disciplined by any healthcare professional licensing authority?

Question 15*

Have you ever been allowed to voluntarily surrender your license in lieu of action by any licensing authority?

Question 16*

Have you ever been the subject of a confidential or non-disciplinary action by a licensing authority?

Question 17*

Have your federal or state controlled substance permits ever been revoked, restricted, or denied?

Medical Education, Training, and Employment

If you answer "Yes" to any question in this section, you are required to submit records and a statement. [See Form U](#).

Unusual Circumstances in Medical School

Question 18*

Did you take a leave of absence of four weeks or longer during medical school?

Question 19*

Have you ever withdrawn from a medical school for any reason?

Question 20*

In medical school, did you ever receive a written warning or documented counseling about your behavior?

Question 21*

In medical school were any limitations or special requirements placed on you for professionalism or behavioral issues?

Question 22*

Was any disciplinary action taken against you in medical school?

Question 23*

Were you ever delayed promotion or advancement to the next level or year in medical school?

Question 24*

Did you ever take a leave of absence during training?

Question 25*

Have you ever resigned from a training program?

Question 26*

In training were any limitations or special requirements placed on you for professionalism or behavioral issues?

Question 27*

In training, did you ever receive a written warning or documented counseling about your behavior?

Question 28*

Were you ever placed on probation for any reason during training?

Question 29*

Are you currently under investigation by your training program?

Question 30*

In training, were any of your privileges or duties ever reduced, suspended, or revoked?

Question 31*

Have you ever received partial or no credit for a postgraduate training program?

Question 32*

In training were you ever delayed promotion or advancement to the next level?

Question 33*

In training were you ever informed your contract would not be renewed?

Question 34*

Have you ever been suspended, terminated or dismissed from a training program?

Unusual Circumstances During Professional Practice or Military Service

If you answer "Yes" to any question in this section, you are required to submit records and a statement. [See Form U](#).

Question 35*

Have you ever been placed on a performance or quality improvement plan of any type for any reason?

Question 36*

Were you ever issued a formal or informal warning, censure, or reprimand?

Question 37*

Were additional limitations or requirements placed on you for any reason?

Question 38*

Were you ever placed on disciplinary probation?

Question 39*

Were your privileges or duties ever reduced, suspended, revoked, or denied?

Question 40*

Were you ever terminated, dismissed, or was your resignation requested?

Question 41*

Did you ever voluntarily resign in lieu of further investigations or other action?

Question 42*

Are you currently under investigation by any governmental agency, health care entity or professional organization?

Question 43*

Have you ever had a complaint, allegation, or investigation result in the non-renewal of contract?

Malpractice History

If you answer "Yes" to any questions in this section, you are required to submit [Form I](#) and [Form V](#).

Question 44*

Has a complaint ever been filed against you in a court (i.e. a lawsuit) seeking damages relating to your conduct in providing or failing to provide a medical or health care service?

Question 45*

Has there been:

a settlement of a claim without the filing of a lawsuit, or
a settlement of a lawsuit

made by you or on your behalf involving damages relating to your conduct in providing or failing to provide a medical or health care service?

Question 46*

While serving in the U.S. military or the Public Health Service, or while employed, contracted or privileged by a federal facility was a complaint filed in court (i.e., a lawsuit) seeking damages relating to your conduct in providing or failing to provide a medical or health care service?

If you answered Yes to Question 44, 45, or 46 above, what is the total number of cases?

Enter the number here:

Mental and Physical Health

If you answer “Yes” to any of the following questions, you are required to submit [Form W](#).

Question 47*

Have you self-referred to the Texas Physicians Health Program? [What is PHP?](#)

Question 48*

Within the past five (5) years, have you abused or have you been addicted to alcohol or drugs or have you been treated or monitored for alcohol or substance abuse/dependency?

Question 49*

Within the past five (5) years, have you been diagnosed with or treated for any psychotic disorder, delusional disorder, mood disorder, major depression, personality disorder, or any other mental condition which impaired or does impair your behavior, judgment, or ability to function in school or work?

Question 50*

Within the past five (5) years, have you had or do you currently have any physical or neurological condition, including any disease or condition generally regarded as chronic, which impaired or does impair your behavior, judgment, or ability to function in school or work?

Question 51*

If you answered "Yes" to questions 48 or 49, are the limitations caused by your mental condition or substance abuse/dependency problem reduced or ameliorated because you receive ongoing treatment (with or without medication) or because you participate in a monitoring program?

Question 52*

Have you completed 60 hours of college courses other than in medical school for credit towards a Bachelor of Arts or Bachelor of Science degree?

Question 53*

Degree Awarded*

Question 54*

Use the drop down list below to locate your medical school. If you are unable to locate your school, please choose "Unassigned", and be aware that this will delay the processing of your application.

Country

State

Medical School

Question 55*

Year degree was awarded (YYYY)*

Question 56*

Did you complete a Fifth Pathway or Pre-Internship program?

Question 57*

Did you complete your entire primary, secondary, and premedical education in the country where your medical school is located?

Question 58*

ECFMG Certification Number

Examination History

Select every qualifying examination from the list below that you have ever attempted: *

- ☐ a. NBME
- ☐ b. NBOME
- ☐ c. FLEX
- ☐ d. USMLE
- ☐ e. COMLEX
- ☐ f. State Board Examination

Specialty Board Certification History

You may enter up to three ABMS or BOS board certifications and the year certification was awarded. Use the drop down lists below to locate your board certification.

Specialty Board Certification History – Primary Certification

Certification
Certification Year (YYYY)

Specialty Board Certification History – Sub-specialty Certification

Certification
Certification Year (YYYY)

Specialty Board Certification History – Additional Certification

Certification
Certification Year (YYYY)
