TEXAS MEDICAL BOARD

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TEXAS MEDICAL BOARD (TMB)
FACULTY TEMPORARY LICENSE APPLICATION
Street Address: 1801 Congress Ave, Ste 9-200, Austin, TX 78701
Mailing Address: PO Box 2029, Austin, TX 78768-2029
Web: www.tmb.state.tx.us

For agency use
4443
$552.00

INSTRUCTIONS TO APPLICANT and MEDICAL SCHOOL/INSTITUTION:

- Allow at least 45 days for processing of application and fee. Requests to expedite due to late submissions will not be considered.
- Complete the application, print, and submit it to the address above.
- Staple a $552.00 personal check, cashier's check or money order (payable through a US bank) to this form.
- Review rules relating to faculty temporary licenses in Chapter 172.8 at http://www.tmb.state.tx.us/page/board-rules

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 Texas Medical Jurisprudence (JP) exam. **Your name must match exactly when you present your identification at the testing center, or you will not be allowed to take the exam.**

1. Last	**2. First**	**3. Middle**	**4. Suffix**

5. Alternate Names:

6. Mailing Address (Note – all correspondence, including the Faculty Temporary License, will be sent to this address):

7. Daytime Telephone Number:	**8. Email Address:** **Fax Number (to send FTL once issued):**
9. Date of Birth (mm/dd/yyyy):	**10. Gender:** ☐ Male ☐ Female
11. Place of Birth (State/Province/Country):	**12. U.S. Social Security Number:**

13. Name and address of requesting teaching institution (must be one of the institutions defined in Board Rule 172.8(a)(3) – see attached):

_____

_____

14. Institution Type (check one):

☐ a. medical school
☐ b. institutional sponsor of a graduate medical education program accredited by the Accreditation Council for Graduate Medical Education
☐ c. nonprofit health corporation certified under Section 162.001 and affiliated with a program as described in (b) above

15. Faculty Department/Specialty: _____

16. Faculty Position/Title: _____
(Assistant Professor, Associate Professor, Professor, Other Equivalent)

17. Begin Date of Position (mm/dd/yyyy): _____ **Expiration Date of Current Permit (if renewal):**_____

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For Military Physicians – a physician is eligible for a faculty temporary license if the physician holds a faculty position of assistant professor-level or higher and works at least *part-time* in one of the institutions named in Board rule 172.8(a)(3) *and* is on active duty in the United States military *and* the physician's practice under the faculty temporary license will fulfill a critical need of the citizens of Texas (as determined by the board).

18. Are you on active duty in the United States Military? **Yes** **No**

19. Will your practice under the Faculty Temporary License fulfill a critical need of the citizens of Texas? **Yes** **No**

If yes, submit a signed statement with this application describing the critical need and your role in fulfilling this need.

Medical Education:

Go to http://www.tmb.state.tx.us/page/full-medical-license to locate the code for your medical school. If you are unable to locate your code, please use the code for an unassigned school.

20. Medical School Code: _____

Name/Location: _____

_____

21. Degree Awarded: MD DO **22. Year degree was awarded** (yyyy) _____

23. Have you completed two years of postgraduate residency training in the US or another country? **Yes** **No**
If yes, submit a copy of your training certificate(s) with this application.

24. Are you licensed to practice medicine in another US state or Canadian province? **Yes** **No**

25. If you are licensed in the US or Canada, is at least one of the licenses current? **Yes** **No**

26. If you are licensed in the US or Canada, are any of your licenses restricted, subject to a disciplinary order, or probation? **Yes** **No**

APPLICANT'S OATH – READ CAREFULLY

I affirm that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am the lawful holder of an M.D., D.O., or equivalent degree as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof.

Further, I hereby authorize the TMB or its successors to release to the staff of the institution requesting this license, any information, which is material to this application.

I hereby affirm that I will provide the Board with updated information to be received by the TMB within 15 days of my becoming aware of any event that occurs after submission of my application that renders any response, although complete and correct when made, no longer complete or correct. Further, failure to provide updates may result in an adverse action against my application.

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I understand that upon issuance of a faculty temporary license my practice of medicine shall be limited to the teaching confines of the applying institution as a part of duties and responsibilities assigned by the institution to the physician and that my practice of medicine is limited to the department and ACGME-accredited program named in this application and the attached Attestation. I understand that, if my appointment is at an accredited school of medicine in this state, the University of Texas Health Center at Tyler, or the University of Texas M.D. Anderson Cancer Center, I may also participate in the full activities of such department of any hospital for which my institution has full responsibility for clinical, patient care, and teaching activities.

I understand that, if a faculty temporary license is issued to me, it will be issued for a period of one year, and that I must submit a new application, fee, and comply with all requirements for any successive faculty temporary license. I understand that under current rules I must take and pass the Texas Medical Jurisprudence Examination within three attempts and that once passed, that score satisfies the Jurisprudence Examination requirement for all subsequent faculty temporary license applications.

Further, I hereby affirm that I have read and am familiar with the board rules and the Medical Practice Act; will abide by board rules and the Medical Practice Act in activities permitted by Board Rule 172.8; and will subject myself to the disciplinary procedures of the board and I have read, understand and accept the terms, limitations and conditions imposed by the TMB on the medical activities of the Faculty Temporary License as defined in Board rule 172.8.

Signature: _____ **Date:** _____

(original signature required)

Printed Name: _____

Position Title: _____

TEXAS MEDICAL BOARD

Attestation – Department Chair or Equivalent

I am submitting this application for a Faculty Temporary License for the above-named physician. I hereby affirm that (check one):

A. For accredited schools of medicine in this state, the University of Texas Health Center at Tyler, or the University of Texas M.D. Anderson Cancer Center:

- ❑ I am the chair of the department of the school or institution in which the above-named physician will teach.

B. For institutional sponsors of a graduate medical education program accredited by the Accreditation Council for Graduate Medical Education:

- ❑ I hold a position equivalent to the chair of the department at the institution in which the above-named physician will teach; the above-named physician will teach in my department; and my department is accredited by ACGME for postgraduate training.

C. For nonprofit health corporations certified under Section 162.001 and affiliated with a program as described in (B) above:

- ❑ I hold a position equivalent to the chair of the department at the institution in which the above-named physician will teach; the above-named physician will teach in my department; and my institution is affiliated with an institution which is ACGME-accredited for postgraduate training program in the same specialty as my department.

I certify that the physician holds a (check one):

- □ full-time, salaried faculty position of assistant professor-level or higher
- □ position equivalent to a full-time, salaried faculty position of assistant professor-level or higher
- □ part-time faculty position of assistant professor-level or higher and; is on active duty in the United States military; and engaged in a practice under the faculty temporary license that will fulfill a critical need of the citizens of Texas
- □ position equivalent to a part-time faculty position of assistant professor-level or higher and; is on active duty in the United States military; and engaged in a practice under the faculty temporary license that will fulfill a critical need of the citizens of Texas

I understand that upon issuance of a faculty temporary license the above-named physician's practice of medicine shall be limited to the teaching confines of my institution as a part of duties and responsibilities assigned by the institution to the physician, and that the physician's practice of medicine is limited to my department and the ACGME-accredited program named in this application. I understand that, if the above-named physician's appointment is at an accredited school of medicine in this state, the University of Texas Health Center at Tyler, or the University of Texas M.D. Anderson Cancer Center, the physician may also participate in the full activities of the department of any hospital for which the institution has full responsibility for clinical, patient care, and teaching activities.

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I understand that, if a faculty temporary license is issued to the above-named physician, it will be issued for a period of one year, and that the above-named physician must submit a new application, fee, and comply with all requirements, including an updated statement by the Chair of the Department or equivalent position and an updated endorsement by the dean of the medical school or president of the institution for any successive faculty temporary license.

I have read, understand and accept the terms, limitations and conditions imposed by the TMB on the medical activities of the Faculty Temporary License as defined in Board rule 172.8. I will provide such information and documentation to the board as may be requested.

Signature: _____ **Date:** _____

(original signature required)

Printed Name: _____

Position Title: _____

TEXAS MEDICAL BOARD

Endorsement - Medical School Dean or Institution President

I am endorsing this application for a Faculty Temporary License for the above-named physician. I hereby affirm that (check one):

A. For accredited schools of medicine in this state, the University of Texas Health Center at Tyler, or the University of Texas M.D. Anderson Cancer Center:

- ❑ I am the dean of the school or institution in which the above-named physician will teach.
- ❑ I am the president of the school or institution in which the above-named physician will teach.

B. For institutional sponsors of a graduate medical education program accredited by the Accreditation Council for Graduate Medical Education:

- ❑ I am the president of the institution in which the above-named physician will teach; the institution is accredited by ACGME for postgraduate training in the department in which the above-named physician will teach; and, not all of the positions at this institution are equivalent to the rank of assistant professor-level or higher.

C. For nonprofit health corporations certified under Section 162.001 and affiliated with a program as described in (B) above:

- ❑ I am the president of the institution in which the above-named physician will teach; my institution is affiliated with an institution which is ACGME-accredited for postgraduate training program in the same specialty in which the above-named physician will teach; and, not all of the positions at this institution are equivalent to the rank of assistant professor-level or higher.

I certify that the signature on the "**Attestation – Department Chair or Equivalent"** above is the signature of the person who holds the position of Chair of the Department or its equivalent.

I certify that the physician: 1) holds a full-time, salaried faculty position of assistant professor-level or higher in this institution; or, 2) holds a faculty position of assistant professor-level or higher, working at least part-time in this institution; and is on active duty in the United States military; and engaged in a practice under the faculty temporary license that will fulfill a critical need of the citizens of Texas.

I understand that upon issuance of a faculty temporary license the above-named physician's practice of medicine shall be limited to the teaching confines of my institution as a part of duties and responsibilities assigned by the institution to the physician, and that the physician's practice of medicine is limited to the specified department and ACGME-accredited program named in this application. I understand that, if the above-named physician's appointment is at an accredited school of medicine in this state, the University of Texas Health Center at Tyler, or the University of Texas M.D. Anderson Cancer Center, the physician may also participate in the full activities of the department of any hospital for which the institution has full responsibility for clinical, patient care, and teaching activities.

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I understand that, if a faculty temporary license is issued to the above-named physician, it will be issued for a period of one year, and that the above-named physician must submit a new application, fee, an updated statement by the Chair of the Department or equivalent, and an updated endorsement by the dean of the medical school or president of the institution for any successive faculty temporary license.

I have read, understand and accept the terms, limitations and conditions imposed by the TMB on the medical activities of the Faculty Temporary License as defined in Board rule 172.8.

I affirm that my medical school or institution:

- **has reviewed the physician's criminal background, disciplinary history with other state licensing entities, and medical malpractice history;**
- **has investigated and determined the physician to be of good professional character;**
- **has investigated and determined the physician to be fit to practice medicine; and,**
- **accepts the responsibility to properly supervise the medical activities of the above-named physician.**

Signature: _____ **Date:** _____

(original signature required)

Printed Name: _____

Position Title: _____

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DPS Computerized Criminal History (CCH) Verification

I, _____ have been notified that a computerized criminal
APPLICANT NAME (Please print)
history (CCH) verification check will be performed by accessing the Texas Department of Public Safety Secure Website and will be based on name and DOB information I supply.

Because the name based information is not an exact search and only fingerprint record searches represent true identification to criminal history, the organization (as listed below) conducting the criminal history check is not allowed to discuss any information obtained using this method, therefore the agency may offer the opportunity to have a fingerprint search performed to clear any misidentification based on the name search, if the search provides a criminal report I know could not be mine.

For the fingerprinting process I will be required to submit a full and complete set of my fingerprints for analysis through the Texas Department of Public Safety AFIS (automated fingerprint identification system). I have been made aware that in order to complete this process I must have the correct fingerprinting (FAST) form from this agency, make an online appointment, submit a full and complete set of my fingerprints, and pay a fee to the fingerprinting services company, L1Enrollment Services.

Once this process is completed and the agency receives the data from DPS, the information on my fingerprint criminal history record may be discussed with me.

_____
Signature of Applicant

_____
Date

Texas Medical Board
Agency Name (Please print)

_____
Agency Representative Name (Please print)

_____
Signature of Agency Representative

_____
Date

Please:
Check and Initial each Applicable Space

CCH Report Printed:

YES _____ NO _____ _____ initial

Purpose of CCH: Applicant background check

Date Printed:_____ _____ initial

Destroyed Date:_____ _____ initial

Retain in your files