# FORM L – PA/AC
# Professional Evaluation

**Texas Physician Assistant Board**
**Texas State Board of Acupuncture Examiners**

APPLICANT SECTION

**APPLICANT:** Complete the information in this box. This form is to be returned to you in a sealed institution envelope with the evaluating professional's signature affixed over the outside envelope flap. You must have evaluations from **every** supervising physician or acupuncturist with whom you have been affiliated in the past 5 years. Make additional copies of this form as needed.

Applicant's Current Full Name: _____Name at time of affiliation if different: _____

Applicant's Date of Birth: _____ Applicant 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:_____

**I authorize the release of the information contained in this evaluation form.**

_____
Applicant's Signature

EVALUATING PROFESSIONAL SECTION

**EVALUATING PROFESSIONAL:**

- A professional who currently holds one of the following positions must complete this evaluation:

  For PAs – Supervising Physician, or, for new graduates, the Program Director.

  For Acupuncturists – An Acupuncturist, or, for new graduates, the Program Director

- Letters of recommendation or standard institution verification forms will not be accepted in lieu of this form.

- After completing this evaluation, 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.
- If you have any questions regarding how to complete this form contact the Licensure Department at 512-305-7130.

**Evaluating Professional Name / Degree**

_____

**Title:** □ Supervising Physician
□ Program Director
□ Acupuncturist

**1.** This evaluation is based on □ Personal Knowledge □ Review of Credential File

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

**3.** (a) Is the applicant related to you? □ Yes □ No
(b) Do you know the applicant well? □ Yes □ No
(c) Has your acquaintance with the applicant continued until recent date? □ Yes □ No

**4.** Do you consider the applicant:
(a) Reliable? □ Yes □ No
(b) Ethical? □ Yes □ No
(c) Of good character? □ Yes □ No

**5.** Please rate the applicant:

| | EXCELLENT | GOOD | AVERAGE | ADEQUATE | POOR |
|---|---|---|---|---|---|
| (a) Professional ability | | | | | |
| (b) Attention to duties | | | | | |
| (c) Breadth of education | | | | | |
| (d) Interpersonal skills | | | | | |

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**Applicant's Name**_____ **Page 2**

**6.** Has applicant, to your knowledge, ever been guilty of:

(a) Fraud or dishonesty? □ Yes □ No

(b) Unprofessional conduct? □ Yes □ No

**7.** If the English language is not the native language of this applicant, do you feel that he/she has the ability to adequately communicate in the English language? □ Yes □ No

**8.** To your knowledge, has the applicant ever:

(a) been warned, censured, disciplined, had admissions monitored or privileges limited? □ 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

**9.** If you answered "yes" to any of the above questions, please provide any additional information you may have, including the names of other individuals who may have information concerning this applicant.

_____

_____

_____

**10.** Are the dates of privileges provided by the applicant on the top portion of this form accurate? □ Yes □ No

If not, please provide the correct dates: Beginning month _____ / year ____Ending month _____ / year _____

**NOTE: All reports received on a licensure applicant are confidential and are not subject to disclosure under the Texas Open Records Act; however, the board must disclose such reports if they are relied upon in a contested denial of licensure.**

**Evaluating Professional's Name:** _____ _____

Printed Signature

Title: _____ Address: _____

Phone: _____ Fax: _____ E-mail: _____

Evaluating Professional's State of Licensure _____ Your License No.: _____

**REMINDER:** Evaluating Professional - after completing this evaluation, 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.