FORM L

Physician Licensure Evaluation Verification of Postgraduate Training and Professional Evaluation Texas Medical Board

APPLICANT: Complete the information in this box. You must have ev		
the past 5 years. Note - your licensure analyst may req	uire additional evaluations outsi	de the past 5 years.
Applicant's Current Full Name:Printed	_Name at time of affiliation if diff	erent: Printed
Applicant's Date of Birth:	Applicant TMB 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	n/yy)	
Department of Affiliation		
Your position at the time of affiliation:	Resident	aculty _\$taff
I hereby authorize all hospitals, institutions or organizar and future), business or professional associates (passfederal, or foreign) to release to the Texas Medical Emedical records, educational records, and records of pedependency, requested by the Board in connection with professional conduct, or physical and/or mental ability Texas Medical Board or its successors to release to the which is material to this application, or any subsequent	t, present and future) and all g Board or its successors any info sychiatric treatment and treatment th this application, necessary to to safely engage in the practice to organizations, individuals, or g	overnmental agencies (local, state, ormation, files or records, including ent for drug and/or alcohol abuse or determine my medical competence, of medicine. I further authorize the
I authorize the release of the information contained	in this evaluation form to the	Texas Medical Board.
Applicant's Signature		
A physician who currently holds one of the following process.		
Chairman, Medical Director, or Training Director. <u>Let</u> not be accepted in lieu of this form.	tters of recommendation or stand	dard institution verification forms will
 After completing this evaluation, place this form in an envelope and place your signature over the outside If you have any questions regarding how to complete 	sealed envelope flap.	
	Title:	☐ Chief of Staff
Evaluating Physician's Name/Degree:		 ☐ Department Chairman ☐ Medical Director ☐ Training Director
	inted	☐ Training Director
Title:		
Phone: Address:		
Evaluating Physician's License Number and State of Licensure		

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This is important: All information on this Form L, (including attachments that you provide as the Evaluating Physician) regarding a licensure applicant is confidential pursuant to §164.007(c) of the Medical Practice Act. However, the Board must provide a copy of this Form L and attachments to an applicant when an application is referred to the Licensure Committee for licensure determination. Any information furnished by you is further subject to Chapter 160.010, of the Medical Practice Act, Immunity from Civil Liability.

	<u> </u>				
VERIFICATION OF	POST GRADUATE TRAINI	NG			
	postgraduate training. If this inc of Professional History section.		ete postgraduate trair	ning at this inst	tution please
PROGRAM PARTICI	PATION:		Department:		
	stgraduate years (PGY)	PGY:	Bopartinont.		
separately from those that were successfully completed.		Internship	From://	To:	
If the postgraduate year is currently in progress,		Residency Fellowship Research	Credit received?		
report the <i>expected</i> completion date in the "To" field.			☐ Full ☐ *Partia	I in progre	SS
Report Internships, Residencies and Fellowships separately. Use one section per department.			*For partial credit-	how many mor	ths?
			Department:		
		PGY:			
		Internship Residency	From://	To:	_//
		Fellowship Research	Credit received?		
		Research	Full *Partia		
	A Bildi i Pil I		*For partial credit—		
UNUSUAL CIRCUMSTANCES:	 Did this individual ever take Did this individual resign fro 			? ∐Yes ∐ No)
Please attach an	3. Were any limitations or specibehavioral issues? ☐ Yes ☐		ed upon this individu	al for professio	nalism or
explanation for any	4. Did this individual ever rece		or documented couns	seling about his	s/her
"yes" response.	behavior? ☐Yes ☐ No 5. Was this individual ever place	ced on probation for a	any reason? □Ves [¬ No	
	6. Is this individual currently ur	nder investigation? []Yes □ No		
		is individual's privileges or duties ever reduced, suspended, or revoked?			
	□Yes □ No		•		. ICVCI:
	 Was this individual informed Was this individual suspen 				lo
VERIEIRATION OF	·				
	PROFESSIONAL HISTORY				
1. This evaluation is	based on Personal Knowled	dge □Review of	f Credential File		
2. How long have you known the applicant? Years Months					
3. Is the applicant re	elated to you?		☐ Yes	□ No	
4. Do you know the applicant well?			☐ Yes	□ No	
5. Has your acquaintance with the applicant continued until recent date?			☐ Yes	□ No	
6. Do you consider the applicant:					
(a) Reliable? (b) Ethical?			☐ Yes ☐ Yes	□ No □ No	
(c) Of good charact	er?			☐ No	
7. Please rate the ap	oplicant:				
	Excellent	Good	Average	Poor]
(a) Professional a					-
(c) Breadth of education					1
(d) Interpersonal:	skills				

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8. Has applicant, to your knowledge, ever been guilty of:	
(a) Fraud or dishonesty?	☐ Yes ☐ No
(b) Unprofessional conduct?	☐ Yes ☐ No
9. To your knowledge, has the applicant ever:	
(a) been warned, censured, reprimanded, disciplined, had admissions monitored or pr	
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?(d) been arrested, fined, charged with or convicted of a crime, indicted, imprisoned	□Yes □No
or placed on probation?	□Yes □No
(e) been a defendant in a legal action involving professional liability (malpractice) or ha	
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?	□Yes □No
11. Are the dates of privileges provided by the applicant on the top portion of this form account of the second of	urate?
12. If not, please provide the correct dates: Beginning month/ yearEnding month	nth/ year
Evaluating Physicians Name: Printed	Signature
Date:	olgilature
REMINDER: Evaluating Physician after completing this evaluation, place this form hospital/institution that you represent, seal the envelope and place you sealed envelope flap. Send to: Texas Medical Board PRC, MC-240 P.O. Box 2029 Austin, TX 78768-2029	