MRT, LMRT, RCP Evaluation
Professional Evaluation
Texas Medical Board

APPLICANT:
Complete the information in this box. You must have evaluations from every facility with which you have been affiliated in the past 5 years. Note – your licensure analyst may require additional evaluations outside the past 5 years.

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

Applicant's Date of Birth: _____ Applicant TMB ID# _____

Applicant's Address: _____ Telephone: _____ E-Mail: _____

Name of Evaluating Hospital/Institution/Practitioner's Office _____

Address of Evaluating Hospital /Institution/Practitioner's Office _____

Dates of employment From (mm/yy) _____ To (mm/yy) _____

Your position at the time of employment: ☐ MRT ☐ LMRT ☐ RCP ☐ NCT ☐ Other_____

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), business or professional associates (past, present and future) and all governmental agencies (local, state, federal, or foreign) to release to the Texas Medical Board or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by the Board in connection with this application, necessary to determine my medical competence, professional conduct, or physical and/or mental ability to safely engage in the practice allowed under my license/certification. I further authorize the Texas Medical Board or its successors to release to the organizations, individuals, or groups listed above, any information, which is material to this application, or any subsequent licensure.

I authorize the release of the information contained in this evaluation form to the Texas Medical Board.

_____
Applicant's Signature

EVALUATING PRACTITIONER:

- After completing this evaluation, place this form in an official envelope of the hospital/institution/clinic that you represented, 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 512-305-7030.

Evaluating Practitioner's Name _____
Printed

Title: _____

Phone: _____ Address: _____

Fax: _____ E-Mail: _____

Evaluating Practitioner's License Number, Type of License, and State of Licensure _____

VERIFICATION OF PROFESSIONAL HISTORY:

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

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

3. Is the applicant related 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? □ Yes □ No
(b) Ethical? □ Yes □ No
(c) Of good character? □ Yes □ No

7. Please rate the applicant:

	Excellent	Good	Average	Poor
(a) Professional ability				
(b) Attention to duties				
(c) Breadth of education				
(d) Interpersonal skills				

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, or disciplined,? □ Yes □ No
(b) had disciplinary action taken against him/her by a licensing agency? □ Yes □ No
(c) had limitations or special requirements placed upon them for professionalism or behavioral issues? □ Yes □ No
(d) received a written warning or documented counseling about his/her behavior? □ Yes □ No
(e) been arrested, fined, charged with or convicted of a crime, indicted, imprisoned or placed on probation? □ Yes □ No
(f) been terminated, resigned in lieu of termination or while under investigation? □ Yes □ No

10. 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.

_____

_____

_____

11. Are the dates of employment provided by the applicant on the top portion of this form accurate? □ Yes □ No

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

Evaluating Practitioner's Name: _____ _____
Printed Signature

Date: _____

REMINDER: Evaluating Practitioner after completing this evaluation, place this form in an envelope of the hospital/institution/clinic that you represent, seal the envelope and place your signature over the outside sealed envelope flap. Send to:
Texas Medical Board
PLCS, MC-240
P.O. Box 2029
Austin, TX 78768-2029