FORM L – Medical Physicists
Medical Physicists Licensure Evaluation
Texas Medical Board

TO BE COMPLETED BY APPLICANT:
Complete the information in the Applicant box only. The remainder of the form should be completed and submitted by the evaluating professional as noted below. Applicant should not upload this form in the LAMAS system. 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: _____

Application for: ☐ Licensed Medical Physicist ☐ Temporary Licensed Medical Physicist ☐ Provisional Medical Physicist

with the specialty(ies) in the area(s) indicated below:

☐ Diagnostic Radiological Physics (DRP) ☐ Therapeutic Radiological Physics (TRP)

☐ Medical Nuclear Physics (MNP) ☐ Medical Health Physics (MHP)

Name of Professional Work Affiliation _____

Address of Professional Work Affiliation _____

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

Your position/title at the time of affiliation: _____

Brief Job Description/Specialty Area:

_____

_____

_____

_____

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

FORM L – Medical Physicists

Applicant's Name_____ **Page 2**
Printed

TO BE COMPLETED BY EVALUATING PROFESSIONAL:

- Please verify the information on the above referenced person. Indicate the medical physics specialty area in which he/she practiced, dates of experience, position/title and provide a brief job description acknowledging that the applicant practiced medical physics during this time period. Letters of recommendation or standard institution verification forms will not be accepted in lieu of this form.
- This completed evaluation should be sent directly to the Texas Medical Board offices. See below for instructions.
- If you have any questions regarding how to complete this form contact the Licensure Department at 512-305-7030.

This is important: All information on this Form L, (including attachments that you provide as the Evaluating Professional) 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.**

VERIFICATION OF PROFESSIONAL HISTORY

1. This evaluation is based on ☐ Personal Knowledge ☐ Review of Personnel 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, disciplined, had privileges limited or suspended, or placed on probation? ☐ Yes ☐ No
(b) had disciplinary action taken against him/her by a licensing agency? ☐ Yes ☐ No
(c) been arrested, fined, charged with or convicted of a crime, indicted, imprisoned or placed on probation? ☐ Yes ☐ No
(d) been terminated, resigned in lieu of termination or during 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 privileges 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 _____

FORM L – Medical Physicists

Applicant's Name_____ **Page 3**
Printed

13. Specialty Area and Brief Job Description of Applicant:

_____

_____

_____

_____

_____

_____

_____

Evaluating Professional's Name, Degree: _____ **Title:** _____
Printed

Phone: _____ Address: _____

Fax: _____ E-Mail: _____

Signature: _____ **Date:** _____

INSTRUCTIONS FOR SUBMITING COMPLETED FORM:

1) By mail - 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.

Send to:
Texas Medical Board
MC-240
P.O. Box 2029
Austin, TX 78768-2029

2) By fax – Evaluator must submit the form along with an official hospital/institution coversheet to 888-790-0621. Fax submitted by the applicant and/or without the appropriate coversheet cannot be accepted.

3) By email – Evaluator must submit the form from an official hospital/institution email address to screen-cic@tmb.state.tx.us. Emails sent from the applicant or from a non-agency email address cannot be accepted.