

PERFORMANCE EVALUATION/SURGICAL ASSISTANT

Texas Medical Board
P.O. Box 2029
Austin, Texas 78768-2029

APPLICANT must complete top portion – (Please Print)

EVALUATING PHYSICIAN (Name, Degree & Institution)

APPLICANT'S FULL NAME

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

Applicant's Signature

EVALUATING PHYSICIAN must complete remaining portion - (Please Print)

INSTRUCTIONS:

- You must be licensed in the United States either as a doctor of medicine or doctor of osteopathic medicine.
- You must have supervised the applicant working as a surgical assistant for a period in the past three years.
- Letters of recommendation are not accepted in lieu of this form.
- This completed evaluation should be sent directly to the Texas Medical Board offices via mail, fax, or email.
 - 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
 - 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.
 - By email - Evaluator must submit the form in PDF format, unsecured and unencrypted, 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.

1. How long have you known the applicant? _____ Years _____ Months
2. In the past 3 years preceding the completion date of this form, how many hours has the applicant worked under your direct supervision as a surgical assistant? _____ Hours
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. Has applicant, to your knowledge, ever been guilty of:
(a) Fraud or dishonesty? Yes No
(b) Unprofessional conduct? Yes No
6. 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
7. 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 arrested, fined, charged with or convicted of a crime, indicted, imprisoned or placed on probation? Yes No
(d) 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
(e) been placed on probation, asked to withdraw or reprimanded? Yes No

8. Please rate the applicant:

- (a) Professional ability
- (b) Attention to duties
- (c) Breadth of education
- (d) Interpersonal skills

EXCELLENT	GOOD	AVERAGE	ADEQUATE	POOR

9. If you answered "yes" to any of the previous questions on #5 and #7 of this form, please provide any additional information you may have, including the names of other individuals who may have information concerning this applicant.

All reports received by the TMB on a licensure applicant are confidential and are not subject to disclosure under the Texas Public Information Act; however, the TMB must disclose such reports to applicants if the reports are relied upon in a contested denial of licensure.

EVALUATING PHYSICIAN – Please Print and Sign Below

Name: _____ Signature: _____

Address: _____
_____ Title: _____

Email: _____ License #: _____ State: _____

Phone: _____ Fax: _____

Date: _____

Evaluating Physician