TEXAS MEDICAL BOARD

VISITING PHYSICIAN TEMPORARY PERMIT APPLICATION

(Applicants should allow 30 days for processing of a Visiting Physician Temporary Permit)

PLEASE TYPE OR PRINT CLEARLY

Visiting Physician's Information

Name: _____MD / DO_____

Email Address: _____

Social Security #:_____

DOB:_____ Place of Birth (State/Province/Country):_____

Medical School of Graduation: _____

Date of Medical School Graduation (mm/dd/yy):_____

Medical License Number(s) and State(s) held:

_____

Texas Sponsoring Physician Information

Name _____ Texas license number:_____

(As imprinted on Texas medical license)

Email Address: _____

Point of Contact for this Application (this will be the individual TMB staff will contact for additional information, if necessary)

Name: _____

Email Address: _____

Telephone Number: _____

Procedure Information

Date(s) of procedure (10 days or less): _____

Location of procedure/event - Hospital/Facility Name _____

Location of procedure/event - Complete Address: _____

_____TX, _____

Name of proposed procedure/event: _____

Brief explanation of procedure/purpose for visit:_____

_____

Location Address:
1801 Congress Ave, Suite 9-200
Austin, Texas 78701

Mailing Address
P.O. Box 2029
Austin, Texas 78768-2029

Phone 512.305.7030
Fax 888.790.0621
Licensure Fax 888.550.7516

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SPONSORING PHYSICIAN ATTESTATION

Note: If multiple sponsoring physicians are to be considered, please have each sponsoring physician complete the attestation.

I, _____, with Active and Unrestricted Texas medical license number _____, attest to the following:

☐ I will provide continuous supervision of applicant: _____.
Applicant Name

☐ I understand that I do not need to be on-site with the applicant during their stay, but I will need to be available, should the need arise.

☐ Date of proposed procedure or event: _____to _____. (Limited to 10 days)
MM/DD/YYYY MM/DD/YYYY

☐ Facility where the proposed procedure or event will be held:

_____

Facility Name City

☐ I understand that if I have been the subject of a disciplinary order with the Texas Medical Board in the past (regardless of reason) that I am ineligible to supervise the applicant.

_____

Print Name

_____ _____

Signature Date

Location Address:
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Austin, Texas 78701

Mailing Address
P.O. Box 2029
Austin, Texas 78768-2029

Phone 512.305.7030
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DPS Computerized Criminal History (CCH) Verification

I, _____ have been notified that a computerized criminal
APPLICANT NAME (Please print)
history (CCH) verification check will be performed by accessing the Texas Department of Public Safety Secure Website and will be based on name and DOB information I supply.

Because the name based information is not an exact search and only fingerprint record searches represent true identification to criminal history, the organization (as listed below) conducting the criminal history check is not allowed to discuss any information obtained using this method, therefore the agency may offer the opportunity to have a fingerprint search performed to clear any misidentification based on the name search, if the search provides a criminal report I know could not be mine.

For the fingerprinting process I will be required to submit a full and complete set of my fingerprints for analysis through the Texas Department of Public Safety AFIS (automated fingerprint identification system). I have been made aware that in order to complete this process I must have the correct fingerprinting (FAST) form from this agency, make an online appointment, submit a full and complete set of my fingerprints, and pay a fee to the fingerprinting services company, L1Enrollment Services.

Once this process is completed and the agency receives the data from DPS, the information on my fingerprint criminal history record may be discussed with me.

_____
Signature of Applicant

_____
Date

Texas Medical Board
Agency Name (Please print)

_____
Agency Representative Name (Please print)

_____
Signature of Agency Representative

_____
Date

Please:
Check and Initial each Applicable Space

CCH Report Printed:

YES _____ NO _____ _____ initial

Purpose of CCH: Applicant background check

Date Printed:_____ _____ initial

Destroyed Date:_____ _____ initial

Retain in your files