



## TEXAS MEDICAL BOARD

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

### SURGICAL ASSISTANT LICENSE APPLICATION

The medical board protects consumers through a comprehensive review of each applicant's competency, professional conduct, and physical and mental ability to safely engage in practice as a surgical assistant.

An applicant who provides false information or a false response to any of the questions is subject to denial of licensure and being reported to the appropriate data banks.

The following information is provided to assist you in the application process:

1. Please visit the board's website at [www.tmb.state.tx.us](http://www.tmb.state.tx.us) and review the board's rules and policies. It is your responsibility to review the rules under Chapter 184, as well as Chapter 206 of the Occupations Code, before signing the Applicant's Oath. These can be found under the Rules & Guidelines on the board's website. Eligibility for licensure in Texas is set out in the board's rules. Review the eligibility checklist available on the board's website at, <http://www.tmb.state.tx.us/page/surgical-assistant-licensure-getting-started>.
2. Complete all of the information on the Application for Surgical Assistant License, the Work Experience form, and the top portion on the Performance Evaluation form. Please type or print clearly.
3. Submit the **\$315.00 licensure fee** in the form of a personal check, cashier's check or money order payable to the Texas Medical Board.
4. Applications are reviewed in the order of receipt.
5. Communication from Board staff regarding licensure applications are primarily via email. Please include a valid, legible email address on your application.
6. Temporary licensure is available for applicants whose files have been determined to be complete. Should you wish to apply for one, please submit the Temporary License Affidavit along with a Temporary License fee. The Temporary License fee is \$50 and should be sent in the form of a personal check, cashier's check or money order payable to the Texas Medical Board. The temporary license will not be issued until your application is complete in every detail. The Temporary License will **not** have a number associated with it.
7. The board awards licenses at its regularly scheduled board meetings. Dates of the medical board meetings are located on the board's website at [www.tmb.state.tx.us](http://www.tmb.state.tx.us). At the time that your application is determined to be complete, you will be informed of the dates of the board meeting at which your application will be considered. In most instances you will not be asked to attend the board meeting.
8. Questions regarding licensure should be directed to staff via email at [screen-cic@tmb.state.tx.us](mailto:screen-cic@tmb.state.tx.us) or by phone at 1-512-305-7130. Please visit the board's website and review the board's rules and policies prior to contacting the board.

# APPLICATION FOR SURGICAL ASSISTANT LICENSE

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

<b>1. NAME:</b>		Last	First	Middle	Suffix (Jr. II, III)
<b>2. CURRENT ADDRESS:</b> (street, city, state, zip) <span style="float: right;">It is YOUR responsibility to notify the Board in writing if you have a change of address.</span>					
<b>3. E-MAIL ADDRESS:</b>					
<b>4. SOCIAL SECURITY NUMBER:</b>			<b>5. DATE OF BIRTH:</b> (month, day, year)		
<b>6. TELEPHONE:</b>					
Home (      )		Work (      )		Cell (      )	
<b>7. SEX:</b> <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		<b>8. CITIZENSHIP:</b> <input type="checkbox"/> U.S. Native <input type="checkbox"/> U.S. Naturalized <input type="checkbox"/> Other (specify)			
<b>9. ETHNIC ORIGIN:</b> (circle) 1. White    2. Black    3. Hispanic    4. Asian or Pacific Islander    5. American Indian or Alaskan Native					
<b>10. POST-SECONDARY EDUCATION:</b>					
Name and Location of School (after high school)	Dates Attended From (mo./yr)    To (mo./yr)	Date Graduated	Sem / Clock Hours	Type of Diploma or Degree Completed	Fields of Study
	-				
	-				
	-				
<b>11. EDUCATIONAL PROGRAM:</b>					
Name & Address of Institution	Program (Surgical Assistant / Medical School / RN First Asst / Surgical PA)	Begin (mo./yr)	End (mo./yr)		
		-	-		
		-	-		
		-	-		
<b>12. EXAMINATION:</b>					
Name of Examination	Date of Examination				
ABSA (American Board of Surgical Assistants)					
NBSTSA (National Board of Surgical Technology and Surgical Assisting) CST/CFA Exam					
NSAA (National Surgical Assistant Association)					
Other:					
<b>13. CURRENT NATIONAL BOARD CERTIFICATION:</b>					
	Date of Certification	Date of Expiration			
ABSA (American Board of Surgical Assistants)					
NBSTSA (National Board of Surgical Technology and Surgical Assisting) CST/CFA Certification					
NSAA (National Surgical Assistant Association)					
Other:					
<b>14. LICENSE, REGISTRATION OR CERTIFICATION IN ANOTHER STATE:</b> (as any health care professional)					
	Number	Year	Current Yes      No		

**AN APPLICANT WHO PROVIDES A FALSE RESPONSE TO ANY OF THESE QUESTIONS IS SUBJECT TO DENIAL OF LICENSURE AND BEING REPORTED TO THE APPROPRIATE DATA BANKS.**

1. Have you ever been arrested?  Yes  No
2. Have you ever been cited or ticketed for, or charged with any violation of the law? (Unless the offense involved alcohol or drugs, you may exclude: 1) traffic tickets; and, 2) violations with fines of \$250 or less.)  Yes  No
3. Are you currently the subject of a grand jury or criminal investigation?  Yes  No
4. Have you ever been convicted of an offense, placed on probation, or granted deferred adjudication or any other type of pretrial diversion? (Unless the offense involved alcohol or drugs, you may exclude: 1) traffic tickets; and, 2) violations with fines of \$250 or less.)  Yes  No
5. Including the incidents above, have you ever been convicted of, or received deferred adjudication for, a felony, a Class A or Class B misdemeanor for:
  - (a) a violation relating to Medicare, Medicaid or insurance fraud?  Yes  No
  - (b) a violation of the Texas Controlled Substance Act or intoxication or alcoholic beverage offense?  Yes  No
  - (c) a violation relating to sexual or assaultive offense?  Yes  No
  - (d) a violation relating to tax fraud or evasion?  Yes  No

**If you answer "Yes" to any of the above questions you must submit a Form R and all documents relevant to each incident along with your application.**

6. Have you ever withdrawn an application for a professional license, permit or certification as a healthcare professional, or have you been determined ineligible for a professional license, permit or certification as a healthcare professional?  Yes  No
7. Have you ever had limitations placed on a professional license, been disciplined, or allowed to resign or voluntarily surrender your license in lieu of action by any licensing authority in any state, province, territory, U.S. federal jurisdiction, or country? (This would include, but is not limited to, informal or confidential orders; consent orders; agreed orders; letters of warning; letters of education; or letters of concern.)  Yes  No
8. Have you ever been the subject of an investigation based on any complaints, inquiries, grievances, formal or informal charges filed (regardless of the outcome) or are there any pending with or by any state, province, territory, US federal jurisdiction, country?  Yes  No
9. Are there now pending any investigations, complaints, inquiries, grievances or formal or informal charges with or by any licensing authority in any state, province, territory, U.S. federal jurisdiction, or country?  Yes  No
10. Have you ever had restrictions placed on, been denied, or required to surrender a federal or state controlled substance permit?  Yes  No

**If you answer "Yes" to any of the above questions you must submit a Form S and all documents relevant to each incident along with your application.**

For this section, an "academic program" is defined to include any of the following: undergraduate education; professional education such as medical, PA, acupuncture school, or other professional education required for licensure; or post-graduate education.

11. Has an academic program, health care entity or professional organization ever taken against you, through either oral or written communication, any of the following public or private actions:
  - limitation, reduction, suspension, revocation or denial of privileges?  Yes  No
  - warning, censure, reprimand, or formal admonishment?  Yes  No
  - additional limitations or requirements placed on you based on your clinical performance, academic performance, discipline, or for any other reason?  Yes  No
  - placement on academic or disciplinary probation?  Yes  No
  - request of termination, withdrawal or resignation?  Yes  No
  - acceptance of voluntary resignation in lieu of further investigations or other action?  Yes  No
12. Are any such actions listed in question 11 pending?  Yes  No

13. Are you currently under investigation by any academic program, health care entity or professional organization?

Yes  No

**If you answer "Yes" to any of the above questions you must submit a Form U and all documents relevant to each incident along with your application.**

14. Has a complaint ever been filed against you in a court (i.e., a lawsuit) seeking damages relating to your conduct in providing or failing to provide a medical or health care service?  Yes  No

15. Has there been: (a) a settlement of a claim without the filing of a lawsuit, or (b) a settlement of a lawsuit made by you or on your behalf involving damages relating to your conduct in providing or failing to provide a medical or health care service?

Yes  No

16. While serving in the U.S. military or the Public Health Service, or while employed, contracted or privileged by a federal facility was a complaint filed in court (i.e., a lawsuit) seeking damages relating to your conduct in providing or failing to provide a medical or health care service?  Yes  No

**If you answer "Yes" to either of the above questions you must submit a Form V and all documents relevant to each incident along with your application and have your Insurance carrier complete Form I.**

17. Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner?

Yes  No

The Texas Physician Health Program (TXPHP) is a confidential program that promotes wellness and the treatment of health conditions that may compromise the ability to practice with reasonable skill and safety. TXPHP is a resource available for all licensees who may suffer from a condition that is or could impair their ability to practice.

TXPHP does not itself treat those who participate, but facilitates a participant's treatment and provides monitoring as needed. Examples of conditions that TXPHP can monitor include: substance abuse and addiction issues, mental health issues, and other medical conditions that may interrupt a licensee's practice. In addition to monitoring, TXPHP provides education, recognition, and assistance in diagnosis, treatment, and management of licensees' potentially impairing conditions.

You may contact TXPHP for further information on the program by calling (512) 305-7462 or via email at [info@txphp.state.tx.us](mailto:info@txphp.state.tx.us). Downloadable self-report forms can be found on the TXPHP website, <http://www.txphp.state.tx.us/>, under the "Forms" section of the website.

**If you answer "Yes" to the above question you must submit a Form W and all documents relevant to each event along with your application.**

**APPLICANT'S OATH**

I, \_\_\_\_\_, do hereby certify, under oath, that I am the person named in this Application for a Surgical Assistant License in the State of Texas; that all statements I have made in the Application for License, are true, correct and complete, to the best of my knowledge; that all documents, forms, credentials, and any other material furnished to the Texas Medical Board (Board) in relation to my application are true, correct, and complete, to the best of my knowledge.

In addition, I understand that a false or misleading statement determined to be fraudulent or deceptive shall result in the denial of a surgical assistant license in accordance with Sections 206.301-.302 of the Texas Occupations Code.

I further state that by filing this Application for a Surgical Assistant License in the State of Texas, I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness to practice as a surgical assistant. I agree to give any further information, which may be required, including but not limited to information requested on this application.

Further, 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 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 professional competence, professional conduct, or physical and or mental ability to safely engage in providing health care services. I further authorize the 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.

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**Signature of Applicant**

# WORK EXPERIENCE/SURGICAL ASSISTANT

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

APPLICANT'S FULL NAME — (Type or print)

## INSTRUCTIONS:

- You must list at least 2000 hours of active experience working as a surgical assistant below.
- The 2000 hours must be within the last three years only and under the direct supervision of a physician licensed in the United States.
- All experience listed below must be verified via "Performance Evaluation/Surgical Assistant" by your supervising physician according to instructions on that form.

	Dates (mo/yr – mo/yr)	Hospital / Clinic & Address	Physician	Hours
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

(Make additional copies of this form as needed, to document 2,000 hours.)

# 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 WORKED AS A SURGICAL ASSISTANT FOR \_\_\_\_\_ HOURS FROM \_\_\_\_\_ TO \_\_\_\_\_  
MM/YY MM/YY

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.
  - Once you complete this form please place in an envelope of the institution/group that you represent, seal the envelope and place your signature over the outside sealed envelope flap.
  - You may return this form to applicant in the sealed envelope or send it directly to the Texas Medical Board via mail.

1. How long have you known the applicant? \_\_\_\_\_ Years \_\_\_\_\_ Months
2. 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(b) Ethical?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(c) Of good character?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Has applicant, to your knowledge, ever been guilty of:
 

(a) Fraud or dishonesty?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(b) Unprofessional conduct?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(b) had disciplinary action taken against him/her by a licensing agency?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(c) been arrested, fined, charged with or convicted of a crime, indicted, imprisoned or placed on probation?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(e) been placed on probation, asked to withdraw or reprimanded?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

8. Please rate the applicant:	EXCELLENT	GOOD	AVERAGE	ADEQUATE	POOR
(a) Professional ability					
(b) Attention to duties					
(c) Breadth of education					
(d) Interpersonal skills					

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.

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10. Please rate the applicant:

	EXCELLENT	GOOD	AVERAGE	ADEQUATE	POOR	N/A
<b>(a) EXPOSURE</b>						
(i) Positions patient appropriately for procedures without direction.						
(ii) Selects, places and holds retractors without direction.						
<b>(b) HEMOSTASIS</b>						
(i) Suctions and sponges without direction.						
(ii) Applies hemostatic devices without direction.						
<b>(c) TISSUE HANDLING</b>						
(i) Demonstrates knowledge and assessment of tissue types.						
(ii) Provides traction and counter-traction without direction.						
<b>(d) SUTURES TISSUE / TIES SUTURE</b>						
(i) Sutures skin (does not include application of skin staples)						
(ii) Sutures sub-Q						
(iii) Sutures facia						
(a) for major pedicles						
(b) on clamped bleeders						
(c) for surgeon-placed stitches						
(d) for fascial stitches						
(e) for sub-Q stitches						
(f) for skin stitches						

11. Are the hours and dates provided by the applicant on the top portion of this form accurate? \_\_\_Yes \_\_\_No

If not, please provide the correct hours and/or dates: Hours \_\_\_\_\_ Beginning MM/YY \_\_\_\_/\_\_\_\_ Ending MM/YY \_\_\_\_/\_\_\_\_

**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: \_\_\_\_\_ **Evaluating Physician**

\_\_\_\_\_ Title: \_\_\_\_\_

Email: \_\_\_\_\_ License #: \_\_\_\_\_ State: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Date: \_\_\_\_\_

**REMINDER:** Evaluating Physician, after completing this evaluation, please place this form in an envelope of the institution/group that you represent, seal the envelope and place your signature over the outside sealed envelope flap.



# INSTRUCTIONS

## FOR COMPLETING YOUR SURGICAL ASSISTANT LICENSURE APPLICATION

The following information is provided in order to help you complete your licensure application forms. Please type or print clearly in ink and provide full details for each question, including dates, complete names, addresses, and zip codes when applicable.

### APPLICATION FOR SURGICAL ASSISTANT LICENSE

You must complete all information on the application form and sign the oath.

### ADDITIONAL DOCUMENTATION

In addition to your application, the following documents are required. Please note other documents may be required. Should other documents be requested, you will be notified by your licensure analyst.

**Birth Certificate/Proof of Age:** You must submit a **copy** of your birth certificate or a **copy** of your current passport.

**Name Change Document:** If any of your documents show a name other than the name on your application, submit one of the following:

- Marriage - Furnish a **copy** of your marriage certificate.
- Divorce - Furnish a **copy** of your divorce decree.
- Adoption - Furnish a **copy** of your adoption order.
- Court Order - Furnish a **copy** of your name change document.

**DPS/FBI Fingerprint Results:** A DPS/FBI fingerprint report will be required as part of the application process. A set of instructions will be emailed to you after receipt of your application.

**Post-Secondary Education (Associate's Degree):** You must have been awarded at least an associate's degree at a two or four year institution of higher education. Request a **certified transcript** issued by the college/university, which indicates the date the degree was awarded, be submitted directly to the board from the college/university.

**Educational Program:** You must have a **certified transcript** of your educational program (either surgical assistant program, medical school, registered nurse first assistant program, or surgical physician assistant program) submitted directly to the board from the program/school in a sealed envelope with the signature of an official of the program/school over the sealed flap. A photocopy of your transcript will not be accepted unless it is sent directly from your educational institution with proper certification.

**Examination Verification:** You must have a letter submitted directly to the board from the appropriate testing service verifying that you passed a surgical assistant examination, or it may be sent to the applicant in a sealed envelope with the signature of an official of the testing service over the sealed flap. If it is sent to the applicant, the applicant must submit it to TMB in the original sealed envelope along with all other forms in the original sealed envelopes. To request your score report, contact the following:

<b>ABSA</b>	<b>(American Board of Surgical Assistants)</b>	<a href="http://www.absa.net">www.absa.net</a>
	303-617-8345 or 877-617-8345	
<b>NBSTSA</b>	<b>(National Board of Surgical Technology and Surgical Assisting)</b>	<a href="http://www.nbstsa.org">www.nbstsa.org</a>
	800-707-0057	
<b>NSAA</b>	<b>(National Surgical Assistant Association)</b>	<a href="http://www.nsaa.net">www.nsaa.net</a>
	602-212-0479 or 888-633-0479	

**Board Certification:** You must submit a **copy** of your valid and current certificate from the **ABSA, NBSTSA, or NSAA.**

**License Verification:** You must request a **letter** of current status (licensure verification) be sent directly to the board from all state/provincial licensing agencies through which you have ever been licensed, registered or certified.

## WORK EXPERIENCE/SURGICAL ASSISTANT

Use this form to document completion of 2000 hours of full-time, active work as a surgical assistant.

List all supervising physicians in the last three years and their facility along with an accurate estimate of total hours worked for each.

You must then have a "Performance Evaluation" completed by each physician that you listed on the Work Experience form. See directions below.

## PERFORMANCE EVALUATION/SURGICAL ASSISTANT

This form must be completed by each physician that you listed on the "Work Experience" form.

The supervising physician may return this form to you in the sealed envelope or send it directly to the Texas Medical Board via mail.

- Letters of recommendation are not accepted in lieu of this form.
- We will not accept residency participation or observerships in lieu of active surgical assistant experience.

Please note: If you have not been supervised by at least three physicians, you will be required to furnish a personal statement providing full details. You will be contacted following receipt of your application regarding this item.

## ADDITIONAL DOCUMENTS

Additional documents are available on the Forms section of the TMB website at the following link, <http://www.tmb.state.tx.us/docs/forms>.

### FORM R

"Yes" response to Question 1-5 of the application.

This form must be completed **ONLY** if you have ever been arrested, convicted or placed on probation per application instructions.

Submit a separate Form R for each event and provide full details.

Have the arresting agency and court involved send legible copies of the arrest documents and court documents relating to the event directly to our Board.

### FORM S

"Yes" response to Question 6-10 of the application.

This form must be completed **ONLY** if you have ever been the subject of disciplinary action by a professional licensing entity as *any* kind of licensed health professional.

Submit a separate Form S for each disciplinary action taken by a professional entity and provide full details.

Have the authority or entity involved in the action send all records regarding the investigation, action or pending action directly to the board's offices.

### FORM U

"Yes" response to Question 11-13 of the application.

This form must be completed **ONLY** if you have ever been the subject of disciplinary actions or investigations in education, training or during employment

Submit a Form U for each disciplinary action taken by while in undergraduate education; professional education such as medical, PA, acupuncture school, or other professional education required for licensure; or post-graduate education and provide full details.

Have the organization or entity involved in the action send all records regarding the investigation, action or pending action directly to the board's offices.

## FORM V

"Yes" response to Question 14-16 of the application.

This form must be completed ONLY if you have ever been named in a claim or action as *any* health professional.

Submit a Form V and detailed statement for each lawsuit or settled claim you have been named in.

Also submit:

- A copy of the plaintiff's original complaint
- A copy of the disposition if the claim resulted in a suit.
- A corresponding "Form I/Surgical Assistant" completed by every carrier with whom a claim has been filed.

If the claim/suit is still pending, have the attorney who represented you (or who is currently representing you) send a letter directly to the board regarding the allegations, defense, current status and/or outcome of the suit.

## FORM I

"Yes" response to Question 14-16 of the application.

This form must be completed ONLY if you have ever been named in a claim or action as *any* health professional.

Submit a Form I For each lawsuit or settled claim you have been named in.

Your liability carrier should complete the remaining portion of the form. The liability carrier may submit a claims report to accompany the Form I.

## FORM W

"Yes" response to Questions 17 of the application. Use additional paper as necessary.

The Texas Physician Health Program (TXPHP) is a confidential program that promotes wellness and the treatment of health conditions that may compromise the ability to practice with reasonable skill and safety. TXPHP is a resource available for all licensees who may suffer from a condition that is or could impair their ability to practice.

TXPHP does not itself treat those who participate, but facilitates a participant's treatment and provides monitoring as needed. Examples of conditions that TXPHP can monitor include: substance abuse and addiction issues, mental health issues, and other medical conditions that may interrupt a licensee's practice. In addition to monitoring, TXPHP provides education, recognition, and assistance in diagnosis, treatment, and management of licensees' potentially impairing conditions.

You may contact TXPHP for further information on the program by calling (512) 305-7462 or via email at [info@txphp.state.tx.us](mailto:info@txphp.state.tx.us). Downloadable self-report forms can be found on the TXPHP website, <http://www.txphp.state.tx.us/>, under the "Forms" section of the website.

You must complete a Form W. Each page must carry a signature and date.

Contact any treating physicians or other record holders and have the records sent directly to the board's offices. Additional details are available on the Form W/Surgical Assistant form itself.

## TEMPORARY LICENSE AFFIDAVIT and FEE

This form must be completed only if you desire a temporary license. The TL will not be issued until after ALL other licensing requirements are met. A TL does not have a license number.