TEXAS MEDICAL BOARD

PROVISIONAL LICENSE VERIFICATION OF EMPLOYMENT OFFER AND AUTHORIZATION

Provisional License Employee Information

Name: _____ ID Number: _____

Title/Position Offered: _____ Specialty: _____

First Day of Employment (MM/DD/YYYY): _____

Employer Information

Last Name, First Name and Title of Employer's Authorized Representative:

_____

Email Address: _____ Phone Number: _____

Employer Name: _____

Employer Address, City, State, ZIP Code:

_____

Name of Facility(s) where the Provisional License holder will practice: (use additional pages if necessary)

	Facility Name	City
1.		
2.		
3.		

Method of Employee Federal Work Authorization Verification:

☐ I-9 Completed and Confirmed through E-Verify

☐ Other: _____

I attest that all the above-named facilities are either facility-based or group practice settings with an Accreditation Council for Graduate Medical Education (ACGME) residency program; or an ACGME-affiliated setting. I further attest that the identity and employment documentation presented by the above-named provisional license employee has been examined, and I verify that this provisional license employee is authorized to work in the United States.

_____

Employer's Authorized Representative Name

_____ _____

Signature **Date**

Location Address:
1800 Congress Ave, Suite 9-200
Austin, Texas 78701

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

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