

FORM L
Physician Licensure Evaluation – Texas Medical Board
Verification of Postgraduate Training and Professional Evaluation

APPLICANT: Complete the information in this box.

Full, Admin, Conceded Eminence, or Physician-in-Training Applicants: 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.

Provisional License or Physician Graduate Applicants: You must have evaluations from every facility with which you have been affiliated in the past 2 years. Note – your licensure analyst may require additional evaluations outside the past 2 years.

Applicant's Current Full Name: _____ Applicant TMB ID# _____

Applicant's Date of Birth: _____

Name of Evaluating Hospital/Institution _____

Address of Evaluating Hospital/Institution _____

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

Department of Affiliation _____

Your position at the time of affiliation: Intern Resident Fellow Faculty Staff Other: _____

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 of medicine. 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

EVALUATING PHYSICIAN:

- A physician who currently holds one of the following positions must complete this evaluation: Chief of Staff, Department Chairman, Medical Director, or Training Director. 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 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 888-550-7516. Fax submitted by the applicant and/or without the appropriate coversheet cannot be accepted.
 - By email - Evaluator must submit the form from an official practice/institution email address to cic@tmb.texas.gov. Emails sent from the applicant cannot be accepted. Only files attached as .pdf or .tif can be safely opened and drop boxes, secured emails, encrypted messages, or links to outside sites cannot be accepted.

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

FOR TRAINING POSITIONS – Completion of the Verification of Post Graduate Training on page 2 and the Verification of Professional History on page 3 are required.

FOR NON-TRAINING POSITIONS – Only completion of the Verification of Professional History on page 3 is required.

FORM L

Applicant's Name _____
Printed _____

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VERIFICATION OF POST GRADUATE TRAINING

Only post-graduate training completed at this institution should be evaluated in this section.

POST GRADUATE TRAINING PROGRAM PARTICIPATION: Report <i>incomplete</i> postgraduate years (PGY) <i>separately</i> from those that were successfully completed. If the postgraduate year is currently in progress, report the <i>expected</i> completion date in the "To" field.	PGY: _____ <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research	Department: _____ From: ____ / ____ / ____ To: ____ / ____ / ____ Credit received? <input type="checkbox"/> Full <input type="checkbox"/> *Partial <input type="checkbox"/> in progress *For partial credit- how many months? _____
	PGY: _____ <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research	Department: _____ From: ____ / ____ / ____ To: ____ / ____ / ____ Credit received? <input type="checkbox"/> Full <input type="checkbox"/> *Partial <input type="checkbox"/> in progress *For partial credit- how many months? _____
	PGY: _____ <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research	Department: _____ From: ____ / ____ / ____ To: ____ / ____ / ____ Credit received? <input type="checkbox"/> Full <input type="checkbox"/> *Partial <input type="checkbox"/> in progress *For partial credit- how many months? _____
	PGY: _____ <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research	Department: _____ From: ____ / ____ / ____ To: ____ / ____ / ____ Credit received? <input type="checkbox"/> Full <input type="checkbox"/> *Partial <input type="checkbox"/> in progress *For partial credit- how many months? _____

UNUSUAL CIRCUMSTANCES: (For training positions only)	<input type="checkbox"/> Yes <input type="checkbox"/> No 1. Did this individual ever take a leave of absence or break from training? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Did this individual resign from training? <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Were any limitations or special requirements placed upon this individual for professionalism or behavioral issues? <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Did this individual ever receive a written warning or documented counseling about his/her behavior? <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Was this individual ever placed on probation for any reason? <input type="checkbox"/> Yes <input type="checkbox"/> No 6. Is this individual currently under investigation? <input type="checkbox"/> Yes <input type="checkbox"/> No 7. Were this individual's privileges or duties ever reduced, suspended, or revoked? <input type="checkbox"/> Yes <input type="checkbox"/> No 8. Did this individual experience delayed promotion or delayed advancement to the next level? <input type="checkbox"/> Yes <input type="checkbox"/> No 9. Was this individual informed his/her contract would not be renewed? <input type="checkbox"/> Yes <input type="checkbox"/> No 10. Was this individual suspended, terminated, or dismissed from training?

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Applicant's Name _____

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VERIFICATION OF PROFESSIONAL HISTORY

1. This evaluation is based on Personal Knowledge Review of Credential File
2. Is this applicant related to you? Yes No
3. Do you consider the applicant:
(a) Reliable? Yes No
(b) Ethical? Yes No
(c) Of good character? Yes No
4. Please rate the applicant:

Excellent	Good	Average	Poor
(a) Professional ability			
(b) Attention to duties			
(c) Breadth of education			
(d) Interpersonal skills			
5. Has applicant, to your knowledge, ever been guilty of:
(a) Fraud or dishonesty? Yes No
(b) Unprofessional conduct? Yes No
6. To your knowledge, has the applicant ever:
(a) been warned, censured, reprimanded, disciplined, had admissions monitored or privileges limited or suspended? Yes No
(b) had disciplinary action taken against him/her by a licensing agency? Yes No
(c) been denied or surrendered a federal or state controlled substance permit? Yes No
(d) been arrested, fined, charged with or convicted of a crime, indicted, imprisoned or placed on probation? Yes No
(e) 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
(f) been placed on probation, asked to withdraw, or reprimanded? Yes No
(g) been terminated, resigned in lieu of termination or during investigation? Yes No

If you answered "yes" to any of Question 5 and/or 6, please provide any additional information you may have, including the names of other individuals who may have information concerning this applicant.

7. Provide dates of affiliation: **Beginning** month _____ / year _____ **Ending** month _____ / year _____

Evaluating Physician's Name/Degree: _____

Title: Chief of Staff Department Chair Medical Director Training Director

Phone: _____ **Fax:** _____

Address: _____

Email Address: _____

Signature: _____ **Date:** _____