Board rule §171.6 states in part that the Director of each approved postgraduate training program shall report in writing to the Executive Director of the Board, the following events within thirty days of the director’s knowledge.

§171.6. Duties of Program Directors to Report.

(a) Failure of any postgraduate training program director to comply with the provisions of this chapter or the Medical Practice Act §160.002 and §160.003 may be grounds for disciplinary action as an administrative violation against the program director.

(b) The director of each approved postgraduate training program shall report in writing to the executive director of the board the following circumstances within thirty (30) days of the director’s knowledge for all participants completing postgraduate training:

1. if a physician did not begin the training program due to failure to graduate from medical school as scheduled or for any other reason(s);
2. if a physician has been or will be absent from the program for more than 21 consecutive days (excluding vacation, military, or family leave not related to the participant's medical condition) and the reason(s) why;
3. if a physician has been arrested after the permit holder begins training in the program;
4. if a physician poses a continuing threat to the public welfare as defined under Tex. Occ. Code §151.002(a)(2), as amended;
5. if the program has taken final action that adversely affects the physician's status or privileges in a program for a period longer than 30 days;
6. if the program has suspended the physician from the program;
7. if the program has requested termination or terminated the physician from the program, requested or accepted withdrawal of the physician from the program, or requested or accepted resignation of the physician from the program and the action is final.

(c) A violation of §§164.051-164.053 or any other provision of the Medical Practice Act is grounds for disciplinary action by the Board.

Source Note: The provisions of this §171.6 adopted to be effective November 7, 2004, 29 TexReg 10107; amended to be effective June 29, 2006, 31 TexReg 5100; amended to be effective August 10, 2008, 33 TexReg 6134; amended to be effective December 18, 2011, 36 TexReg 8377; amended to be effective December 23, 2012, 37 TexReg 9773.
PROGRAM DIRECTOR’S REPORT

Name of Permit Holder: ____________________________________________
(Please type or print name as it appears on permit)

TMB Personal ID Number: __________________________________________

Social Security #: ________________________________________________

Permit Number: ________________________________________________

Date of Event/Action: ____________________________________________

Please furnish specific details and/or reasons for the report, including specific dates and/or changes. If more room is needed, please use the reverse side of this form. You may be asked to furnish more information after Board staff has reviewed your report. Thank you.

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

Date of notification to TMB: _______________________________________

Signature and title of supervising physician submitting notification to TMB:

_________________________________________________________________

Please type or print name, title and email address of the supervising physician submitting notification:

_________________________________________________________________

Training program name, address and specialty: ________________________

_________________________________________________________________
June 12, 2009

To: Physician in Training (PIT) Permit Holders

From: Texas Medical Board, Licensure Division - Physician in Training Section

Subject: PIT Holder Reports

Board rule §171.5 states in part that each PIT holder shall report in writing to the Executive Director of the Board, the following events within thirty days of their occurrence.

§171.5. Duties of PIT Holders to Report.

(a) Failure of any PIT holder to comply with the provisions of this chapter or the Medical Practice Act §160.002 and §160.003 may be grounds for disciplinary action as an administrative violation against the PIT holder.

(b) The PIT holder shall report in writing to the executive director of the board the following circumstances within thirty days of their occurrence:

1. the opening of an investigation or disciplinary action taken against the PIT holder by any licensing entity other than the TMB;
2. an arrest, fine (over $250*), charge or conviction of a crime, indictment, imprisonment, placement on probation, or receipt of deferred adjudication; and
3. diagnosis or treatment of a physical, mental or emotional condition, which has impaired or could impair the PIT holder’s ability to practice medicine.

You may use the form on the following page to make a report. The contact information for the Board is at the bottom of the page.
PHYSICIAN IN TRAINING PERMIT HOLDER’S REPORT

Name: 

(Please type or print name as it appears on permit)

TMB Personal ID Number: 

Social Security #: 

Permit Number: 

Training program name, address and specialty:

E-Mail Address: 

Date of Event/Action: 

Please furnish specific details and/or reasons for the report, including specific dates and/or changes. If more room is needed, please use the reverse side of this form. You may be asked to furnish more information after Board staff has reviewed your report. Thank you.

Signature 

Date 

Location Address: 333 Guadalupe, Tower 3, Suite 610
Austin, Texas 78701

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

Phone 512.305.7030
Fax 512.463-9416
Licensure Fax 512.305.7009
www.tmb.state.tx.us
REVISED Physician Licensure Application Questions

Actions and Investigations in Medical Education and Training

If you answer "Yes" to any question in this section, you are required to submit records and a statement. See Form U.

Unusual Circumstances in Medical School

Question 15
Did you take a leave of absence of four weeks or longer during medical school?

Question 16
Have you ever withdrawn from a medical school for any reason?

Question 17
In medical school, did you ever receive a written warning or documented counseling about your behavior?

Question 18
In medical school were any limitations or special requirements placed on you for professionalism or behavioral issues?

Question 19
Was any disciplinary action taken against you in medical school?

Question 20
Were you ever delayed promotion or advancement to the next level or year in medical school?

Unusual Circumstances During Postgraduate Training

Question 21
Did you ever take a leave of absence during training?

Question 22
Have you ever resigned from a training program?

Question 23
In training were any limitations or special requirements placed on you for professionalism or behavioral issues?

Question 24
In training, did you ever receive a written warning or documented counseling about your behavior?

Question 24
Were you ever placed on probation for any reason during training?

Question 26
Are you currently under investigation?

Question 27
Were any of your privileges or duties ever reduced, suspended, or revoked?

Question 28
Have you ever received partial or no credit for a postgraduate training program?

Question 29
In training were you ever delayed promotion or advancement to the next level?

Question 30
In training were you ever informed your contract would not be renewed?

Question 31
Have you ever been suspended, terminated or dismissed from a training program?

Mental and Physical Health

If you answer "Yes" to any of the following questions, you are required to submit Form W.

Question 41
Have you self-referred to the Texas Physicians Health Program?

Question 42
Within the past five (5) years, have you abused or have you been addicted to alcohol or drugs or have you been treated or monitored for alcohol or substance abuse/dependency?

Question 43
Within the past five (5) years, have you been diagnosed with or treated for any psychotic disorder, delusional disorder, mood disorder, major depression, personality disorder, or any other mental condition which impaired or does impair your behavior, judgment, or ability to function in school or work?

Question 44
Within the past five (5) years, have you had or do you currently have any physical or neurological condition, including any disease or condition generally regarded as chronic, which impaired or does impair your behavior, judgment, or ability to function in school or work?

Question 45
If you answered "Yes" to questions 42 or 43, are the limitations caused by your mental condition or substance abuse/dependency problem reduced or ameliorated because you receive ongoing treatment (with or without medication) or because you participate in a monitoring program?
Actions to Report/Disclose

These actions should always be reflected on the Form L evaluation, or any accompanying letter, report, or training or medical student file sent to the Board.

- Termination – dismissal from the program or school.
- Non-renewal of contract – resident is allowed to complete the year, but not continue in the program, or not continue in the program until requested remediation is complete.
- Resignation of permit-holder – whether voluntary or requested, whether immediate or at the end of a year, semester, or period.
- Suspension – of privileges, duties, or from the program or school.
- Delayed promotion – student or resident is allowed to continue in the school or program, but not allowed to advance to the next level without some remediation or additional requirements, up to and including repeating the year.
- Probation – period of additional oversight or requirements to address deficiencies.
- Pending investigation – whether or not student or resident is suspended during investigation.
- Any action taken for dishonesty.
- Repeated instances of counseling, warnings, remediation, performance or academic improvement plans taken by the program or school. More than two incidents would be considered repeated.

Actions or Events That Do Not Need to be Disclosed

These actions, events, or documents do not need to be reflected on the Form L evaluation, or any accompanying letter, report, or training or medical student file sent to the Board.

- Medical students – academic issues that did not get referred to the Promotions Committee.
- Midpoint or routine evaluations that were remediated.
- Additional rotations during training due to lack of patient volume and availability.
- Negative evaluations from peers.
- Instances of counseling, warnings, remediation, performance or academic improvement plans that do not occur more than twice while enrolled. If this is tied to any action that must be reported the single instance of counseling must be reported.
FORM L
Physician Licensure Evaluation
Verification of Postgraduate Training and Professional Evaluation
Texas Medical Board

APPLICANT:
Complete the information in this box. 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.

Applicant’s Current Full Name: __________________________ Name at time of affiliation if different: __________________________ Printed
Applicant’s Date of Birth: __________________________ Applicant TMB ID# __________________________
Applicant’s Address: __________________________ Telephone: __________________________ E-Mail: __________________________

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

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.

• After completing this evaluation, place this form in an envelope of the hospital/institution that you represented, seal the envelope and place your signature over the outside sealed envelope flap.

• If you have any questions regarding how to complete this form contact the Licensure Department at 512-305-7030

Evaluating Physician’s Name/Degree: __________________________ Printed
Title: __________________________
Phone: __________________________ Address: __________________________
Fax: __________________________ E-Mail: __________________________
Evaluating Physician’s License Number and State of Licensure __________________________
**VERIFICATION OF POST GRADUATE TRAINING**

This section relates to postgraduate training. If this individual did not complete postgraduate training at this institution please skip to the Verification of Professional History section.

<table>
<thead>
<tr>
<th>PGY:</th>
<th>Department:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PROGRAM PARTICIPATION:**

Report *incomplete* postgraduate years (PGY) separately from those that were successfully completed.

If the postgraduate year is currently in progress, report the *expected* completion date in the “To” field.

Report Internships, Residencies and Fellowships separately. Use one section per department.

**UNUSUAL CIRCUMSTANCES:**

Please attach an explanation for any “yes” response.

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

**VERIFICATION OF PROFESSIONAL HISTORY**

1. This evaluation is based on  ☐ Personal Knowledge  ☐ Review of Credential File

2. How long have you known the applicant?  Years _______  Months _______

3. Is the applicant related to you?  ☐ Yes  ☐ No

4. Do you know the applicant well?  ☐ Yes  ☐ No

5. Has your acquaintance with the applicant continued until recent date?  ☐ Yes  ☐ No

6. Do you consider the applicant:
   - (a) Reliable?  ☐ Yes  ☐ No
   - (b) Ethical?  ☐ Yes  ☐ No
   - (c) Of good character?  ☐ Yes  ☐ No

7. Please rate the applicant:
   - (a) Professional ability
   - (b) Attention to duties
   - (c) Breadth of education
   - (d) Interpersonal skills

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Good</th>
<th>Average</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
FORM L

Applicant's Name ___________________________________________ Printed

8. Has applicant, to your knowledge, ever been guilty of:
   (a) Fraud or dishonesty? □ Yes □ No
   (b) Unprofessional conduct? □ Yes □ No

9. 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

10. If you answered "yes" to any of the above questions, please provide any additional information you may have, including the names of other individuals who may have information concerning this applicant.

__________________________________________________________________________
__________________________________________________________________________

11. Are the dates of privileges provided by the applicant on the top portion of this form accurate? □ Yes □ No

12. If not, please provide the correct dates: Beginning month ___ / year ___ Ending month ___ / year ___

Evaluating Physicians Name: ____________________________________________
Printed _______  Signature _______

Date: __________________________

REMINDER: Evaluating Physician after completing this evaluation, 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
PRC, MC-240
P.O. Box 2029
Austin, TX 78768-2029