TEXAS MEDICAL BOARD

TO: Postgraduate Training Program Directors

FROM: Texas Medical Board, Licensure Dept - Physician in Training Section

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.

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

TEXAS MEDICAL BOARD

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: _____

_____

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

TEXAS MEDICAL BOARD

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.

~~*This amount is currently $100 in rule, but it in the process of being changed to $250. Report only fines over $250.~~

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.

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

TEXAS MEDICAL BOARD

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

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 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.

Title: ☐ Chief of Staff
☐ Department Chairman
☐ Medical Director
☐ Training Director

Evaluating Physician's Name/Degree: _____
Printed

Title: _____

Phone: _____ Address: _____

Fax: _____ E-Mail: _____

Evaluating Physician's License Number and State of Licensure _____

FORM L

Applicant's Name_____ **Page 2**
Printed

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.**

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.

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.

PGY: _____ ___ Internship ___ Residency ___ Fellowship ___ Research	Department: _____ From: ___/___/___ To: ___/___/___ Credit received? ☐ Full ☐ *Partial ☐ in progress *For partial credit– how many months?_____
PGY: _____ ___ Internship ___ Residency ___ Fellowship ___ Research	Department: _____ From: ___/___/___ To: ___/___/___ Credit received? ☐ Full ☐ *Partial ☐ in progress *For partial credit– how many months?_____

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:

	Excellent	Good	Average	Poor
(a) Professional ability				
(b) Attention to duties				
(c) Breadth of education				
(d) Interpersonal skills				

FORM L

Applicant's Name_____ **Page 3**
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

Sample PIT Application

Login

Physician in Training (PIT) Permit Application

Get this from your program before you apply:

- Your TMB personal ID number
- The third party identification number for your residency program (only needed if they will be paying your application fee)

Note:

- Information you enter will be automatically saved at the end of every page.
- You must complete the application within 15 days or your information will be deleted.
- Some of the questions may direct you to download a supplemental form and submit it, along with any relevant records.
- Pay the license fee using one of the following:
  - MasterCard,
  - Visa,
  - Discover,
  - American Express, or
  - Electronic Check.
  - Third Party Pay.

Check Your Eligibility

FAQ

Processing times can vary depending on the acceptability of submitted items and the complexity of your application. Some of the factors that can increase complexity are "yes" answers to the professionalism questions on this application.

Asterisk (*) indicates response required.

TMB personal ID Number*:

Date of Birth (MM/DD/YYYY)*:

Continue

Sample PIT Application

Confirm Login

First Name: XXXXXXXX

Last Name: XXXXXXXX

Date of Birth: XX/XX/XXXX

	Begin	Apptype	Personal ID	Program	Program Name	Amount
Select	XX/XX/XXXX	Rotator	123456	XXXXXXXXXX	XXXXXX	$XXX.XX

If you are not **XXXXX XXXXX**, please do not continue. Please contact the Texas Medical Board.

Sample PIT Application

Identification

You are applying for the XXXX PIT Permit.

Your name on this application must match the name submitted by your residency program.

Asterisk (*) indicates response required.

Full Name as you wish it to appear on your receipt*:

Applicant First/Middle Name*:

Applicant Last Name*:

Suffix:

Alternate Names:

Social Security Number (XXX-XX-XXXX or XXXXXXXXX):

Email Address (XX@XX.XXX)* Note: if you do not have an email account, please enter the email address of your program.

Gender*:
- ○ Male
- ○ Female

Race*:

Are you of Hispanic Origin?*:
- ○ Yes
- ○ No

Country of Birth*:

If you were born in the United States, please select your state of birth:

US State of Birth:

Continue

Sample PIT Application

Address

Please provide your current mailing address and **daytime** U.S. phone number. **It is your responsibility to notify the Board in writing if you have a change of address.**

All correspondence will be sent to the mailing address. When entering a foreign address leave the State blank and provide a Country.

If you do not have a U.S. phone number, enter the telephone number for your program.

Asterisk (*) indicates response required.

Mailing address

Mailing Address 1*:

Mailing Address 2:

Mailing City*:

Mailing State:

Mailing Zip Code*:

Province:

Mailing Country*:

Telephone Number ###-###-####*:

Continue

Sample PIT Application

Training and Work History

- List all activities since graduation from medical school including:
  - All US or Canadian post graduate training since graduation from medical school.
  - All periods of unemployment or employment outside the field of medicine. For periods of unemployment, use your home address.
- To indicate a current position, enter today's date as an end date.
- You must send our evaluation form (Form L) to each training program in the US or Canada that you listed. Please note that you may be asked to send a Form L to any other positions listed on your application.
- If a listed training facility is no longer operating, please submit Form Q.

Add Training and Work History

Asterisk (*) indicates response required.

Position*:

Department*:

Start Date (MM/YYYY)*:

End Date (MM/YYYY)*:

Facility/Employer Name*:

Facility/Employer Street*:

Facility/Employer City*:

Facility/Employer State:

Facility/Employer ZIP/Postal Code*:

Facility/Employer Province:

Facility/Employer Country*:

Facility/Employer Phone Number (###-###-####):

Submit Cancel

Sample PIT Application

Professional History

Attention: This is important. Be sure to disclose all relevant disciplinary actions, charges, or convictions. A false response to any of these questions may be grounds for disciplinary action, or even denial of licensure. Avoid some of the common excuses heard from people who fail to disclose, such as:

- My attorney told me I didn't have to disclose the criminal conduct or disciplinary actions.
- I didn't think the prior conduct had anything to do with the profession.
- I didn't think the disciplinary action, arrest, charges, or conviction was still on my record.
- I didn't think it was subject to disclosure because I received a deferred sentence/judgment.
- My program director/faculty advisor said it wouldn't appear on my record.

All supplemental forms listed can be found on the Additional Forms section of our website.

Asterisk (*) indicates response required.

Question 1*

Have you ever had (or applied for) a license, permit or certification as a healthcare professional in any state, province, territory, U.S. federal jurisdiction, or country?

○ Yes
○ No

Question 2

Have you ever participated in or been enrolled in, or are you now participating in or enrolled in, any U.S. or Canadian internships, residencies or fellowships? If you answer "Yes" please submit a copy of each of your training certificates by fax or mail to the TMB. If a certificate is not available, request the program director at the program to fax or mail a Form L to the TMB. See the FAQ page for contact information.

○ Yes
○ No

Arrest/Criminal History

This is important:

The Board will run queries with the Texas Department of Public Safety (and the FBI) to verify your criminal history. Both entities maintain records, often beyond the time that courts keep them. Please be aware that if you have **ever** been arrested, charged, or convicted of a misdemeanor or a felony, the record of those events will be reported as a

result of the fingerprint inquiry.

Serious traffic offenses such as reckless driving, driving under the influence of alcohol and/or drugs, hit and run, evading a peace officer, failure to appear, driving while the license is suspended or revoked MUST be reported. This list is not all-inclusive. If in doubt as to whether an offense should be disclosed, it is better to disclose the offense on the application.

Matters in which you were diverted, deferred, pardoned, or pled nolo contendere MUST be disclosed.

If you believe your offense was **sealed or expunged**, you **must** be able to provide a copy of the expunction or non-disclosure order if requested.

If you are in doubt as to how to respond to the questions, full and honest disclosure is highly recommended.

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

Question 3*

Have you ever been arrested?

- ○ Yes
- ○ No

Question 4*

Have you ever been charged with any violation of the law regardless of outcome? (Unless the offense involved alcohol or drugs, you may exclude: 1) traffic tickets; and, 2) violations with fines of $250 or less.)

- ○ Yes
- ○ No

Question 5*

Are you currently the subject of a grand jury or criminal investigation?

- ○ Yes
- ○ No

Sample PIT Application

Question 6*

Have you ever been placed on probation?

- ○ Yes
- ○ No

Question 7*

Have you ever been 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

Question 8*

Have you ever been convicted of an offense or imprisoned?

- ○ Yes
- ○ No

Including the incidents you reported in Questions 3-8 above, have you been convicted of, or received deferred adjudication for, a felony, a Class A or Class B misdemeanor for a violation relating to:

(required – see Tex. Occ. Code, Sec. 156.001(e)). If you answer "Yes", submit Form R.

Question 8a*

Medicare, Medicaid or Insurance fraud

- ○ Yes
- ○ No

Question 8b*

the Texas Controlled Substances Act or intoxication or alcohol beverage offenses

- ○ Yes
- ○ No

Sample PIT Application

Question 8c*

sexual or assaultive offenses

- ○ Yes
- ○ No

Question 8d*

tax fraud or evasion

- ○ Yes
- ○ No

Actions by Health Professional Licensing or Certification Authorities

(Including but not limited to licensing and/or regulatory agencies, specialty boards, and licensing exam administration authorities)

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

Question 9*

Have you ever withdrawn an application for a license, permit or certification as a healthcare professional

- ○ Yes
- ○ No

Question 10*

Have you ever been determined ineligible for a license, permit or certification as a healthcare professional?

- ○ Yes
- ○ No

Question 11*

Are you currently the subject of an investigation by any health professional licensing or certification authority?

- ○ Yes
- ○ No

Sample PIT Application

Question 12*

Have you ever had limitations, conditions, or restrictions placed on a healthcare professional license

- ○ Yes
- ○ No

Question 13*

Have you ever been disciplined by any healthcare professional licensing authority?

- ○ Yes
- ○ No

Question 14*

Have you ever been allowed to voluntarily surrender your license in lieu of action by any licensing authority?

- ○ Yes
- ○ No

Question 15*

Have you ever been the subject of a confidential or non-disciplinary action by a licensing authority?

- ○ Yes
- ○ No

Question 16*

Have your federal or state controlled substance permits ever been revoked, restricted, or denied?

- ○ Yes
- ○ No

Sample PIT Application

Medical Education, Training and Employment

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 17*

Did you take a leave of absence of four weeks or longer during medical school (for any reason)?

- ○ Yes
- ○ No

Question 18*

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

- ○ Yes
- ○ No

Question 19*

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

- ○ Yes
- ○ No

Question 20*

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

- ○ Yes
- ○ No

Question 21*

Was any disciplinary action taken against you in medical school?

- ○ Yes
- ○ No

Sample PIT Application

Question 22*

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

- ○ Yes
- ○ No

Unusual Circumstances In Training

Question 23*

Did you ever take a leave of absence during training (for any reason)?

- ○ Yes
- ○ No

Question 24*
Have you ever resigned from a training program (for any reason, including transfer to another program)?

- ○ Yes
- ○ No

Question 25*

In training were any limitations or special requirements placed on your for professionalism or behavioral issues?

- ○ Yes
- ○ No

Question 26*

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

- ○ Yes
- ○ No

Sample PIT Application

Question 27*

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

- ○ Yes
- ○ No

Question 28*

Are you currently under investigation by your training program?

- ○ Yes
- ○ No

Question 29*

In training, were any of your privileges or duties ever reduced, suspended, or revoked?

- ○ Yes
- ○ No

Question 30*

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

- ○ Yes
- ○ No

Question 31*

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

- ○ Yes
- ○ No

Question 32*

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

- ○ Yes
- ○ No

Sample PIT Application

Question 33*

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

- ○ Yes
- ○ No

Unusual Circumstances During Professional Practice or Military Service

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

Question 34*

Have you ever been placed on a performance or quality improvement plan of any type for any reason?

- ○ Yes
- ○ No

Question 35*

Were you ever issued a formal or informal warning, censure, or reprimand?

- ○ Yes
- ○ No

Question 36*

Were additional limitations or requirements placed on you for any reason?

- ○ Yes
- ○ No

Question 37*

Were you ever placed on disciplinary probation?

- ○ Yes
- ○ No

Sample PIT Application

Question 38*

Were your privileges or duties ever reduced, suspended, revoked, or denied?

- ○ Yes
- ○ No

Question 39*

Were you ever terminated, dismissed, or was your resignation requested?

- ○ Yes
- ○ No

Question 40*

Did you ever voluntarily resign in lieu of further investigations or other action?

- ○ Yes
- ○ No

Question 41*

Are you currently under investigation by any governmental agency, health care entity or professional organization?

- ○ Yes
- ○ No

Question 42*

Have you ever had a complaint, allegation, or investigation result in the non-renewal of contract?

- ○ Yes
- ○ No

Sample PIT Application

Malpractice History

If you answer "Yes" to any questions in this section, you are required to submit Form I and Form V.

Question 43*

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

Question 44*

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

Question 45*

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 answered Yes to Question 43, 44, or 45 above, what is the total number of cases?

Enter the number here: [ ]

Sample PIT Application

Mental and Physical Health

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

Question 46*

Have you self-referred to the Texas Physicians Health Program? What is PHP?

- ○ Yes
- ○ No

Question 47*

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 other substance abuse/ dependency?

- ○ Yes
- ○ No

Question 48*

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?

- ○ Yes
- ○ No

Question 49*

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?

- ○ Yes
- ○ No

Sample PIT Application

Question 50

If you answered "Yes" to questions 47 or 48, 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?

- ○ Yes
- ○ No

Question 51

Degree Awarded*

Question 52

Use the drop down list below to locate your medical school. If you are unable to locate your school, please choose “Unassigned”, and be aware that this will delay the processing of your application.

If you have to choose Unassigned as your school code, you must send an email to pits@tmb.state.tx.us with the name and address of your medical school. Be sure to include your name, TMB Personal ID number and contact information.

Country

State

Medical School

Question 53

Year degree was awarded (YYYY)*

Question 54

ECFMG Certification Number
(no dashes/hyphens allowed)

Continue

Sample PIT Application

Review

Please review your information carefully and use the links on the left hand side to return to any section that needs modification. Click the “Continue” button at the bottom of the page when you are ready to move on. You may print this page if necessary.

Asterisk (*) indicates response required

Continue

Sample PIT Application

Attestation

I certify that I am the Applicant and I have personally filled in the responses in this Application. I have read and understand all parts of this application; I am the person named in all supplemental information and credentials submitted in support of this application; all of the information contained in this application and all supplemental information and credentials submitted in support of this application are true and correct; all supplemental information and credentials submitted in support of this application are or will be procured without fraud or misrepresentation or any mistake of which I am aware; and I am the lawful holder of all supporting credentials.

I 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, the Texas Physician Assistant Board, or the Texas State Board of Acupuncture Examiners, or their 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, and/or physical and mental ability to safely engage in the practice of my profession. I further authorize the Texas Medical Board, the Texas Physician Assistant Board, or the Texas State Board of Acupuncture Examiners, or their successors to release to the organizations, individuals, or groups listed above any information that is material to this application, or any subsequent licensure.

I will provide updated information to the Board, which shall be received by the Board within 15 days after I become aware of the fact that any response made on my application, although complete and correct when made, is no longer complete or correct.

I agree that any falsification or misrepresentation of any item or response on this application, any falsification or misrepresentation of supplemental information, or any failure to provide updated information is a sufficient basis for a determination of ineligibility or any other adverse action against my application.

I agree to these terms. ☐