Dear Applicant:

The Texas Medical Board is pleased you have chosen to apply for licensure using the Uniform Application for Physician State Licensure (UA). The Uniform Application benefits physicians applying to more than one participating medical or osteopathic board during the span of their career by reducing data entry redundancy. The core Uniform Application information can be updated and sent as needed.

**The Federation Credentials Verification Service (FCVS)**

As part of the licensure process, the Board highly recommends, but does not require, the use of FCVS for credentials verification. Applicants not using FCVS must provide their credentials directly to the Board for verification.

FCVS verifies primary source documents related to your identity, medical education, postgraduate training, examination history, board action and disciplinary history, and certain certifications. During the verification process, FCVS creates a personalized profile that eliminates the re-verification of items that never change. The FCVS profile can be updated as needed throughout a physician’s career, resulting in a shortened credentialing process when applying to more than one state board.

To work on the initial FCVS application for creating a profile or the subsequent FCVS application for updating an existing profile, visit [http://www.fsmb.org/](http://www.fsmb.org/) and select FCVS in the Licensure or Sign In menu, then sign in as directed. For assistance, use the messaging tool within FCVS or call 888-275-3287 with your FCVS ID number between 8am and 5pm CT Monday through Friday.

For assistance with FCVS, use the messaging tool within FCVS or call 888-275-3287 with your FCVS ID or Federation ID number between 8am and 5pm CT Monday through Friday.

**Completing the Online Uniform Application (UA)**

Read the following information carefully before completing and submitting your application. You will be asked to account for all time since medical school graduation, including providing your employment history, and asked to provide any information on medical malpractice claims. We recommend having this information on hand before you begin working on your UA.

To work on the UA, go to [http://www.fsmb.org/](http://www.fsmb.org/) and select Uniform Application from the Licensure menu or Sign In menu. If you have submitted a UA, select the state board in the State Board section to open the UA for editing. Submit your UA to the board when you have finished updating your UA.

Please note the following:

- Provide both your current home address and current business practice or training address, otherwise an error will occur. Do not enter the same address for both home and work.
• MD and DO licenses cannot be added or edited in the UA as all MD and DO license information comes directly into the system from the state boards. Email ua@fsmb.org with the correct information if changes are needed. Depending on volume of license update requests, it may take 1-3 business days for the changes to appear in your UA.

• Enter all other professional licenses (nurse, EMT, physician assistant, etc.) you have held (active or inactive) in the U.S. or Canada. Request verification from these boards as well.

• If you hold licenses in countries outside the U.S. or Canada, please provide that information on a separate sheet of paper to the Board.

• If you have no malpractice claims, you may leave that section blank.

• First time UA users will be taken to a payment page for a one-time service fee of $50. This is a separate fee collected by FSMB and is separate from FCVS fees. A receipt will be available immediately after UA submission for printing and a separate receipt will be emailed to you.

• In lieu of a state addendum and all UA forms, upon submission of your UA, you will be redirected to the Texas Medical Board’s website to complete the Texas application. Your UA data should already be included in the Texas application. To complete the Texas application at a later time, log in at https://applications.tmb.state.tx.us/PH/identification1.aspx and click on the “Get FSMB information” button. Enter the Application ID found in your UA confirmation email to transfer information from your UA into the Texas application. Continue and complete the Texas application and all applicable forms as directed.

• To open an already submitted UA for editing, select the Board from the State Board section. Update your UA as needed, then resubmit your UA to the Board. A new Application ID will be generated upon resubmission. Use the new Application ID in the Texas application.

Uniform Application Tips

The UA FAQ at https://www.fsmb.org/licensure/uniform-application/faq answers the most common UA questions. If your question or issue isn’t listed, contact UA customer service at 800-793-7939 or email ua@fsmb.org with your username or FCVS ID if applicable, and a description of what you were doing at the time.

For questions about the application process or the status of your Texas licensure application, please refer to http://www.tmb.state.tx.us/page/licensing or contact the Texas Medical Board at 512-305-7010.
Affidavit and Authorization for Release of Information

Applicant: In the presence of a notary public, sign this form with attached photo. If you are using FCVS for credentials verification, consider having that form notarized at the same time. Send the separate notarized FCVS form to FCVS. Do not send this form to FCVS as doing so will delay your licensure.

Send this form to the board you are applying to for licensure. Include all other required materials. A directory of state medical and osteopathic boards is available at http://www.fsmb.org/policy/contacts.

Please send this form to: Texas Medical Board
P.O. Box 2018
Austin, TX 78768-2018

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application, and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Uniform Application for Physician State Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data, and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge, and exonerate the Board, its agents or representatives, and any person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the Board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the Board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.

 Applicant Photograph

Securely tape or glue a recent (per the board’s instructions) front-view 2” x 2” passport-type color photo of yourself in this square.

Applicant’s signature (must be signed in the presence of a notary)

Applicant’s printed last name, first name, middle initial, and suffix (e.g., Jr.)

Date of signature (must correspond to date of notarization)

[Please note: The Notary Public seal should overlap the bottom of the photo to the left.]

NOTARY

State of __________________________, County of __________________________.

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant’s signature made in my presence on this form with the signature on his/her identifying document.

The statements on this document are subscribed and sworn to before me by the applicant on this _____ day of __________, 20____.

Notary Public Signature ____________________________________________ My Notary Commission Expires ______________
Licence Verification Form (Form #1)

Applicant: Most boards require verification of each professional license ever held. Refer to the licence verification resource at [http://www.fsmb.org/licensure/uniform-application/](http://www.fsmb.org/licensure/uniform-application/) to determine fees and preferred verification method(s) for each state medical and osteopathic verifying board. You may use this form for each board that requires a written request for verification. In Section 1, list the board you are applying to for licence, using the directory at [http://www.fsmb.org/policy/contacts](http://www.fsmb.org/policy/contacts) to ensure you list the correct name and address. Mail this completed form and any required fee to the verifying board.

Verifying Board: Unless using electronic verification, complete Section 2 below and mail this form to the board at the address listed in Section 1. Use an additional sheet of paper if needed for explanation(s).

**Section 1: Applicant Information**

First name ___________________________ Last name ___________________________ Practitioner Type □ MD □ DO □ _____

Middle name ___________________________ Suffix ________ SSN* ___________ Birth date (mm/dd/yyyy) ______________

*The social security number is to be used for purposes of identification only and may not be used for any other reason.

Authorization for Verifying Board: I am applying for a license to practice medicine. The board that I am applying to for licence requires that this form or an otherwise accepted method of verification be completed by all boards through which I hold or have held licenses, whether now current or not. I authorize the licensing agency of the state/province of ________________ to provide any and all information pertaining to my license number ________________ to the board at the address listed below.

Board name Texas Medical Board
Mailing address P.O. Box 2018
City/State/Zip Austin, TX 78768-2018

Applicant signature ___________________________ Date ______________

**Section 2: Board Verification of Licensure**

Name of issuing board or license entity ____________________________________________________________

Name of licensee (last, first, middle, suffix) _______________________________________________________

License type __________ License number ___________ Issue date ___________ Expiration date ___________

1. Is this license current? If not current, please explain: □ Yes □ No

2. Have formal disciplinary proceedings been initiated against this applicant’s license by a disciplinary authority in your state? If yes, please explain on a separate sheet of paper and attach it to this form.

3. Has the applicant ever been warned, censured, placed on probation, formal consent, reprimand, or in any other manner disciplined, or has the applicant’s license ever been revoked, suspended, or, in any other manner, limited by a licensing or disciplinary authority in your state? If yes, please explain on a separate sheet of paper and attach it to this form.

**I CERTIFY THAT** to the best of my knowledge and belief, the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature ____________________________________________

Print name ________________________________

Title ___________________________ Date ____________

AFFIX INSTITUTIONAL SEAL HERE

(If no seal is available, this form must be notarized.) Phone number ________________________ Fax number ____________

Email ________________________________

Please mail this completed form and any other items to the board at the address listed in Section 1. Thank you.
Medical or Osteopathic School Verification Form (Form #2)

Applicant: DO NOT COMPLETE THIS FORM IF YOU ARE USING FCVS. FCVS verifies this data for you. If you are not using FCVS, complete Section 1 below. Send this form and a copy of your medical school diploma to the current dean of your medical or osteopathic school. Copy this form for multiple schools.

Dean or Designated Official: Complete Section 2 of this two-page form and certify the enclosed copy of the diploma by placing your school seal on it. Mail the sealed diploma, an official copy of the physician’s transcripts, this completed form, and any other documentation needed to the board at the address listed in Section 1. If transcripts are not in English, an original, certified, and official English translation is required.

Section 1: Applicant Information

First name ______________________  Last name ______________________  Practitioner Type □ MD □ DO □ __
Middle name ______________________  Suffix _____  SSN* _________  Birth date (mm/dd/yyyy) __________

Name if different when diploma awarded: ___________________________________________________________

Name of school ______________________

*The social security number is to be used for purposes of identification only and may not be used or any other reason.

Waiver for Release of Information: I am applying for a license to practice medicine. I authorize the medical/osteopathic school listed above to provide any and all information pertaining to my medical/osteopathic education at that institution to the board at the address listed below. I request that the dean or a designated official complete Section 2 of this form and seal the copy of my diploma (attached) as described in the instructions above, then mail this completed form, the sealed diploma copy, and a copy of my official transcripts to the board listed below at the given address:

Board name Texas Medical Board
Mailing address P.O. Box 2018
City/State/Zip Austin, TX 78768-2018

Applicant signature ___________________________________________  Date ______________

Section 2: Medical or Osteopathic School Verification

School name ______________________________________________________________
Complete address w/country ________________________________________________

School name if different when applicant attended _____________________________________

Hours of undergraduate education required for admission ______  Total weeks of education applicant attended ______

Attendance (mm/yyyy) from _______ to _______  Graduation date _______  Degree awarded _______

Unusual Circumstances

The following questions apply to unusual circumstances that occurred during any part of the individual’s medical or osteopathic education. Check the appropriate responses and provide dates and requested information. “Yes” responses to any of these questions require a copy of explanatory records or a written explanation attached to this form.

1. Do the official records for this individual reflect interruptions or extensions in his/her Yes □ No □ medical/osteopathic education? If yes, indicate the reasons for each interruption or extension, the dates of each interruption or extension, and whether each interruption or extension was approved or unapproved.

□ Personal or family  From ___________ to ___________  □ Approved □ Unapproved
□ Academic remediation  From ___________ to ___________  □ Approved □ Unapproved
□ Health  From ___________ to ___________  □ Approved □ Unapproved
□ Financial  From ___________ to ___________  □ Approved □ Unapproved
□ Participation in a joint degree program  From ___________ to ___________  □ Approved □ Unapproved
□ Participation in a non-research special study (e.g., fellowship, intl. experience)  From ___________ to ___________  □ Approved □ Unapproved
□ Other ___________________________  From ___________ to ___________  □ Approved □ Unapproved
2. Do the official records for this individual reflect that he/she was ever placed on academic or disciplinary probation during his/her medical/osteopathic education? **If yes**, indicate below the reasons for each time of probation and the dates of placement on and removal from probation. Also attach documentation or information of each circumstance and outcome.

   - [ ] Academic From ________________ to ________________ Yes [ ] No [ x ]
   - [ ] Unprofessional conduct From ________________ to ________________ Yes [ ] No [ x ]
   - [ ] Behavioral reasons From ________________ to ________________ Yes [ ] No [ x ]
   - [ ] Other ________________ From ______ to ________ Yes [ ] No [ x ]
   - [ ] Documentation attached

3. Do the official records for this individual reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical/osteopathic school or parent university? **If yes**, explain below and/or attach documentation or information of each circumstance and outcome.

4. Do the official records for this individual reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical/osteopathic school or parent university? **If yes**, explain below and/or attach documentation or information of each circumstance and outcome.

5. Do the official records for this individual reflect that there were ever any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? **If yes**, explain below and/or attach documentation or information of each circumstance and outcome.

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**I CERTIFY THAT** to the best of my knowledge and belief, the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature ________________________________
Print name ________________________________

AFFIX INSTITUTIONAL SEAL HERE
(If no seal is available, this form must be notarized.)

Title ________________________________ Date ________________
Phone number ________________ Fax number ________________
Email ________________________________

Please mail this completed form and any other items to the board at the address listed in Section 1. Thank you.
### Section 1: To be completed by the Applicant

**Name:**

**SUFFIX**

**Practitioner type:** M.D. □ D.O. □

**Date of birth:** _________ (mm/dd/yyyy)  SSN* ____________

*The social security number is to be used for purposes of identification only and may not be used for any other reason.

**Name if different when diploma awarded:**

**Waiver for Release of Information:** I request that the program director or a designated official complete Section 2 of this form as outlined below. I authorize the postgraduate training program listed above to provide any information pertaining to my training there to the board listed below:

**Board Name:**

**Mailing address:**

**Applicant Signature:** ___________________________  **Date** __________

### Section 2: Program Participation

**Important:**

- **Report Incomplete Training Levels (years) separate from those that were successfully completed.**
- If the training level (year) is currently in progress report the expected completion date in the “To” field.
- Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.
- Report Internships, Residencies and Fellowships separately.

**Unusual Circumstances:**

Check the appropriate responses and explain any “Yes” or omitted response(s) on a separate sheet of paper.

**Certification:** Affix your institutional seal in this space. If no seal is available, you must have this form notarized.

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate and complete statement of the record of the individual named on this form. This section **MUST** be signed by the program director (M.D. or D.O. only). Please Note: The Nevada Board of Medical Examiners requires an authorization letter to be attached if this form is completed by someone other than an M.D. or D.O.

**Signature:** __________________________________________

**Print name:** ___________________________

**Title:** __________________________

**Email address:** __________________________

**Phone Number:** __________________________  **Date:** __________
Fifth Pathway Verification Form (Form #4)

Applicant: DO NOT COMPLETE THIS FORM IF YOU ARE USING FCVS. FCVS verifies this data for you. If you are not using FCVS, complete Section 1 below. Send this form to your Fifth Pathway program director.

Program Director or Designated Official: Complete Section 2 of this form. Mail this completed form and any other documentation (if applicable) to the board at the address listed in Section 1.

Section 1: Applicant Information

First name __________________ Last name ________________________ Practitioner Type □ MD □ DO □ ___
Middle name __________________ Suffix ______ SSN* _______________ Birth date (mm/dd/yyyy) _______________

Name if different when diploma was awarded: ________________________________________________________________

Name of medical school _______________________________________________________________________________________________________________________

*The social security number is to be used for purposes of identification only and may not be used for any other reason.

Waiver for Release of Information: I request that the program director or a designated official complete Section 2 of this form as outlined above. I authorize the designated official to provide any and all information pertaining to my time there to the board listed below:

Board name __________________________ Mailing address __________________________
City/State/Zip __________________________

Applicant signature ___________________________________________________________ Date ______________

Section 2: Fifth Pathway Verification

Institution name _________________________ Affiliated school __________________________

Institution name if different when applicant attended _________________________________

Institution address w/country __________________________

Type of Clinical Rotation ________________________________________________________________________________________________

From ___________ To ___________ Weeks Credit ___

Completed? □ Yes. Attendance was from ___________ to ___________. Completion date was ___________.

□ No. Withdrawal* date was ___________. *If the applicant withdrew or was dismissed, please explain below.

□ No. Dismissal* date was ___________. *If the applicant withdrew or was dismissed, please explain below

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature __________________________
Print name __________________________

AFFIX INSTITUTIONAL SEAL HERE

Title __________________________ Date ______________

(If no seal is available, this form must be notarized.) Phone number __________________ Fax number __________

Email __________________________

Please mail this completed form and any other items to the board at the address listed in Section 1. Thank you.

Uniform Application for State Licensure

April 2018