

Text Facsimile of Online Physician-in-Training (PIT) Application

Login

Physician in Training (PIT) Permit Application Licensure 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 be 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

FACSIMILE ONLY – DO NOT USE TO APPLY.
APPLY ONLINE AT WWW.TMB.STATE.TX.US.

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.

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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*:	<input type="text"/>
Applicant First/Middle Name*:	<input type="text"/>
Applicant Last Name*:	<input type="text"/>
Suffix:	<input type="text"/>
Alternate Names:	<input type="text"/>
Social Security Number (XXX-XX-XXXX or XXXXXXXXXX):	<input type="text"/>
Email Address (XX@XX.XXX)* Note: if you do not have an email account, please enter the email address of your program.	<input type="text"/>

Gender*: <input type="radio"/> Male <input type="radio"/> Female
--

Race*:

Are you of Hispanic Origin?*: <input type="radio"/> Yes <input type="radio"/> No
--

Country of Birth*:

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

US State of Birth:

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

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*:	<input type="text"/>
Department*:	<input type="text"/>
Start Date (MM/YYYY)*:	<input type="text"/>
End Date (MM/YYYY)*:	<input type="text"/>
Facility/Employer Name*:	<input type="text"/>
Facility/Employer Street*:	<input type="text"/>
Facility/Employer City*:	<input type="text"/>
Facility/Employer State:	<input type="text"/>
Facility/Employer ZIP/Postal Code*:	<input type="text"/>
Facility/Employer Province:	<input type="text"/>
Facility/Employer Country*:	<input type="text"/>
Facility/Employer Phone Number (###-###-####):	<input type="text"/>

Submit

Cancel

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.

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 to verify your criminal history. You may be required to get fingerprinted for the FBI as well. 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.

Question 3*

Have you ever been arrested? If you answer "Yes" to this question, you are required to submit [Form R](#).

- Yes
- No

Question 4*

Have you ever been cited or ticketed for, or charged with any violation of the law? (Unless the offense involved alcohol or drugs, you may exclude: 1) traffic tickets; and, 2) violations with fines of \$250 or less.) If you answer "Yes" to this question, you are required to submit [Form R](#).

- Yes
- No

Question 5*

Are you currently the subject of a grand jury or criminal investigation? If you answer "Yes" to this question, you are required to submit [Form R](#).

- Yes
- No

Question 6*

Have you ever been convicted of an offense, placed on probation, or 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.) If you answer "Yes" to this question, you are required to submit [Form R](#).

- Yes
- No

Including the incidents you reported in Questions 3-6 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 7a*

Medicaid, Medicare or Insurance fraud

- Yes
- No

Question 7b*

the Texas Controlled Substances Act or intoxication or alcohol beverage offenses

- Yes
- No

Question 7c*

sexual or assaultive offenses

- Yes
- No

Question 7d*

tax fraud or evasion

- Yes
- No

Actions by Professional Licensing Entities

If you answer "Yes" to any question in this section, you are required to submit [Form S](#).

Question 8*

Have you ever withdrawn an application for a professional license, permit or certification as a healthcare professional, or have you been determined ineligible for a professional license, permit or certification as a healthcare professional? If you answer "Yes" to this question, you are required to submit [Form S](#).

- Yes
- No

Question 9*

Have you ever had limitations placed on a professional license, been disciplined, or allowed to resign or voluntarily surrender your license in lieu of action by any licensing authority in any state, province, territory, U.S. federal jurisdiction, or country? (This would include, **but is not limited to**, informal or confidential orders; consent orders; agreed orders; letters of warning; letters of education; or letters of concern.) If you answer "Yes" to this question, you are required to submit [Form S](#).

- Yes
- No

Question 10*

Have you **ever** been the subject of an investigation based on any complaints, inquiries, grievances or formal or informal charges filed (regardless of the outcome) with or by any licensing authority in any state, province, territory, U.S. federal jurisdiction, or country? If you answer "Yes" to this question, you are required to submit [Form S](#).

- Yes
- No

Question 11*

Are there now pending any investigations, complaints, inquiries, grievances or formal or informal charges with or by any licensing authority in any state, province, territory, U.S. federal jurisdiction, or country? If you answer "Yes" to this question, you are required to submit [Form S](#).

- Yes
- No

Question 12*

Have you ever had restrictions placed on, been denied, or been required to surrender a federal or state controlled substance permit? If you answer "Yes" to this question, you are required to submit [Form S](#).

- Yes
- No

Actions and Investigations in Education, Training or During Employment

If you believe that any action or investigation was not reportable, you **must** read the instruction on [Form U](#) before you answer "No" to ensure your full and honest disclosure. An "academic program" is defined to include any of the following: undergraduate education, medical, school, or post-graduate education.

Has any academic program, health care entity or professional organization ever taken against you, through either oral or written communication, any of the following public or private actions:

Question 13a*

limitation, reduction, suspension, revocation or denial of privileges? If you answer "Yes" to this question, you are required to submit [Form U](#).

- Yes
- No

Question 13b*

warning, censure, reprimand, or formal admonishment? If you answer "Yes" to this question, you are required to submit [Form U](#).

- Yes
- No

Question 13c*

additional limitations or requirements placed on you based on your clinical performance, academic performance, discipline, or for **any** other reason? If you answer "Yes" to this question, you are required to submit [Form U](#).

- Yes
- No

Question 13d*

placement on academic or disciplinary probation? If you answer "Yes" to this question, you are required to submit [Form U](#).

- Yes
- No

Question 13e*

request of termination, withdrawal or resignation? If you answer "Yes" to this question, you are required to submit [Form U](#).

- Yes
- No

Question 13f*

acceptance of voluntary resignation in lieu of further investigations or other action? If you answer "Yes" to this question, you are required to submit [Form U](#).

- Yes
- No

Question 14*

Are any such actions listed in questions 13a through 13f pending? If you answer "Yes" to this question, you are required to submit [Form U](#).

- Yes
- No

Question 15*

Are you currently under investigation by any academic program, health care entity or professional organization? If you answer "Yes" to this question, you are required to submit [Form U](#).

- Yes
- No

Malpractice History

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

Question 16*

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? If you answer "Yes" to this question, you are required to have [Form I](#) completed by every malpractice carrier who has insured you and you are required to submit [Form V](#).

- Yes
 No

Question 17*

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? If you answer "Yes" to this question, you are required to have [Form I](#) completed by every malpractice carrier who has insured you and you are required to submit [Form V](#).

- Yes
 No

Question 18*

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? If you answer "Yes" to this question, you are required to have [Form I](#) completed for each complaint and you are required to submit [Form V](#).

- Yes
 No

If you answered Yes to Question 16, 17, or 18 above, what is the total number of cases?

Enter the number here:

Mental and Physical Health

If you answer "Yes" to any of the following questions, you are required to submit [Form W](#).

Question 19a*

Within the past five (5) years, have you abused or have you been addicted to alcohol or drugs or have you been treated for alcohol or other substance abuse or dependency? If you answer "Yes" to this question, you are required to submit [Form W](#).

- Yes
- No

Question 19b*

Within the past five (5) years, have you been diagnosed with or treated for any of the following: schizophrenia or any other psychotic disorder, delusional disorder, bipolar or manic depressive mood disorder, major depression, personality disorder, or any other mental condition which impaired your behavior, judgment, or ability to function in school, work or other important life activities? If you answer "Yes" to this question, you are required to submit [Form W](#).

- Yes
- No

Question 19c*

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 by the medical community, which impaired or does impair your behavior, judgment, or ability to function in school, work or other important life activities? If you answer "Yes" to this question, you are required to submit [Form W](#).

- Yes
- No

Question 19d*

Within the past five (5) years, have you been diagnosed with or treated for pedophilia, exhibitionism, voyeurism, frotteurism, or sexual sadism? If you answer "Yes" to this question, you are required to submit [Form W](#).

- Yes
- No

Question 20

If you answered "Yes" to questions 19a or 19b, 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 21

Degree Awarded*

Question 22

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 23

Year degree was awarded (YYYY)*

Question 24

ECFMG Certification Number
(no dashes/hyphens allowed)

Continue

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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

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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.

Continue

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Payment

- Credit card
- Check
- Third Party

Third Party Payment number:

[Continue](#)

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APPLY ONLINE AT WWW.TMB.STATE.TX.US.

If Third Party Payment is indicated:

Congratulations

Your application has been successfully submitted into the payment queue for your program. They will have 15 days to pay for your application before the date is deleted.

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APPLY ONLINE AT WWW.TMB.STATE.TX.US.

Credit Card/Electronic Check:

In order to complete the payment for your application, you will leave the TMB website and be directed to the Texas.gov payment processing site. Texas.gov, the official website of the State of Texas, processes online transactions on behalf of State Agencies. Your bill will indicate that this transaction has been charged to **TMB PHY Application**.

No financial information is seen, processed, or stored by the Texas Medical Board.

The payment portion of the online registration system is handled by Texas.gov, the official website of Texas. The price of this service includes funds that support the ongoing operations and enhancements of Texas.gov, which is provided by a third party in partnership with the State, as well as processing fees. Texas.gov will remit the amount paid to the Texas Medical Board on your behalf. Please note that the Texas.gov portion is non-refundable.

The total amount you will pay will be \$XXX.XX

Please press the continue button to begin entering payment information (NOTE: the payment process may take several minutes to finish. Please be patient and DO NOT click the back button or close your browser).

Press to continue

Payment Process

Customer Billing Information

Name*

Company Name

Billing Address*

Billing Address 2

Billing City*

Country*

State

ZIP/Postal Code*

Phone Number *
(XXX-XXX-XXXX or XXXXXXXXXXX)

Email Address*

Receipt Email Address

Enter the email address you want copies of the confirmation receipt sent to.

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Credit Card Information

Credit Card Type*

Credit Card Number*

Expiration Date*

Name on Credit Card*

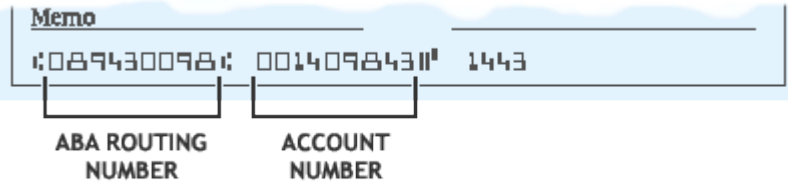
exactly as it appears on the card

Verification Code*

Sample Only - Apply Online

FACSIMILE ONLY – DO NOT USE TO APPLY.
APPLY ONLINE AT WWW.TMB.STATE.TX.US.

Electronic Check Information



Account Type*

Routing Number*

Account Number*

Re-enter Account Number*

Bank Name*

Name on Account*

Driver License Number*

Driver License State*

Default Payment Date

Default Payment Date

Select if this payment IS being funded specifically by a **FOREIGN** source (bank or company), an International ACH Transaction ("IAT").

As defined by NACHA, IAT means a credit or debit entry that is part of a payment transaction involving a financial agency's office that is not located in the territorial jurisdiction of the United States. For purposes of this definition a financial agency means an entity that is authorized by applicable law to accept deposits or is in the business of issuing money orders or transferring funds. An office of a financial agency is involved in the payment transaction if it:

1. Holds an account that is credited or debited as part of the payment transaction;
2. Receives payment directly from a Person or makes payment directly to a Person as part of the payment transaction; or
3. Serves as an intermediary in the settlement of any part of the payment transaction.

Continue

Cancel Payment