Texas Department of State Health Services
Medical Advisory Board Appointment Application

Please complete this application in a brief yet informative manner.
If questions are not applicable, please enter "NA."

1. Personal Information:

Title | First Name | MI | Last Name | License #

Specialty -Choose One- | If other, please specify. | Appointment Type -Choose One-

Street/PO Box | Ste/Apt # | Home Phone

City | State | Zip Code | County | Cell Phone

Email | Fax Number

2. Employer/Clinic:

Name | Position

Street/PO Box | Suite # | Business Phone

City | State | Zip Code | County | Business Cell

Business Email | Business Fax

3. Where would you like to receive future communications? Work

4. Race/Ethnicity: -Please Specify- **Gender:** ___ Male ___ Female

5. Educational Background:

6. **Are you currently serving, or have you served on any other boards or committees?** -Please Choose-

   If so, please specify which committees or boards:

   _____

   What is the board or committee's purpose?

   _____

   Please list any current or former membership or board position(s) you have held with other organizations:

7. **Relevant Experience (paid or volunteer):**

   Note: Resumes will not be considered.

8. **Why do you wish to serve on the Texas Department of State Health Services Medical Advisory Board?**

9. **Please list personal and professional achievements, including activities that address contributions that you could make to the committee/council/ board/panel:**

10. **Do you currently have any open complaints or disciplinary actions pending or have you ever been disciplined by any licensing board or professional/civic organization?**
__ No current or past complaint/disciplinary action.
__ Yes, current complaint/disciplinary action pending.
__ Yes, past complaint/disciplinary action.

If yes, please explain:

_____

11. **Have you ever been convicted of a felony or a misdemeanor (excluding traffic violations)?** __ No __ Yes

If yes, please explain:

_____

12. **Please list two references that may be contacted for verification of application information and qualifications.**

Name	Address	Phone	Email
_____	_____	_____	_____
Name	Address	Phone	Email
_____	_____	_____	_____

I ATTEST THAT ALL INFORMATION CONTAINED IN THIS DOCUMENT IS TRUE AND CORRECT.

_____ _____

Signature of Applicant Date

PRIVACY NOTIFICATION: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004).

CLICK TO SUBMIT

Texas Department of State Health Services
Medical Advisory Board (MC 1876)
P.O. Box 149347
Austin, Texas 78714-9347
Applications can also be submitted via email at dshsmab@dshs.texas.gov or faxed to (512) 834-6736.