Please fill out this form completely and accurately. Do not leave any questions blank. If you are unsure of how to answer a question, write that down. If a question does not apply, then put "N/A". The completed form can be scanned and emailed to the following email address: info@txphp.texas.gov. If you prefer, you can fax or mail the completed form using the contact information listed below.

You will be contacted within 5 working days after sending us your self-report. If you have not been contacted by then, please call the TXPHP at (512) 305-7462.

All records and information maintained by the TXPHP are confidential under Sec. 167.010 of the Medical Practice Act and are not subject to disclosure except as otherwise stated therein.

Texas Physician Health Program (TXPHP)
1801 Congress Ave, Suite 9-500
Austin, TX 78701
Phone: (512) 305-7462
Fax: (512) 463-0216

Self-Report Form

Date: _____

I am self-reporting the following (check all that apply):

Substance Use and/or Addiction ☐ Mental Health Condition ☐ Physical Illness ☐

Do you hold a license from the Texas Medical Board (TMB) or an advisory board for the TMB? **Yes/No** (select one)

If yes, what is your license number: _____

If no, do you have a pending application with the TMB? **Yes/No** (select one)

If you do not have a license or a pending application, do you plan to apply for a license with the TMB in the future? **Yes/No** (select one)

If yes, please explain when you plan to apply. If no, please explain why you are self-referring to TXPHP:

_____

_____

I am self-reporting to TXPHP because of the following issue(s):

_____

_____

_____

_____

Did anyone encourage you to make this self-report? **Yes/No** (select one)

If yes, who? _____

_____

Do you consent to have the TXPHP reach out to this person(s) to gather additional information about your self-referral? **Yes/No** (select one)

Personal Data:

Full name: _____

Date of birth: _____

Professional degree or license (MD/DO/PA or “other”): _____

Medical specialty/practice: _____

Other licenses held (other state, country, etc.): _____

Preferred mailing address for TXPHP communications:

_____

_____

Preferred telephone number(s) for contact by TXPHP:

Cell: _____

Home: _____

Work: _____

Email Address _____

I grant permission to TXPHP to communicate with me via email. **Yes/No** (select one)

Background Information:

I **have/do not have** (select one) legal charges pending against me. If applicable, here are details on charges that are or may be pending: _____

_____

I **have/do not have** (select one) a pending complaint or open investigation with the TMB. If applicable, here are details: _____

_____

I hold a medical (professional) license in the following states: _____

I **have/have not** (select one) had my license suspended or revoked. If so, please explain: _____

_____

I **am/am not** (select one) currently involved in ongoing investigations by any state licensing board. If so, please explain:

_____

_____

I **am/am not** (select one) currently involved in any malpractice actions. If so, please explain: _____

_____

I **am/am not** (select one) currently involved in any other legal actions. If so, please explain: _____

_____

My DEA status is **Active/Surrendered/Other** (select one). Include dates of surrender. If other, explain, e.g., in training and use institutional license. _____

_____

Provide a statement which contains:

1) A description of any incident that may have resulted in a breach of the standard of care that occurred during a period of impairment or,
2) If no breach of the standard of care may have occurred, a statement that no breach of the standard of care occurred.

_____

_____

_____

I **am/am not** (select one) currently under investigation by a peer review or wellness committee. If applicable, here are the details (allegations, any action taken, etc.) and the name and address of the entity conducting the inquiry:

_____

_____

_____

I **am/am not** (select one) currently practicing/working. If applicable, here are the details (solo, group, institutional, etc.) and the practice address:

_____

_____

I **do/do not** (select one) participate in another state's Physician Health Program. If applicable, here are the states:

_____

I understand that answering "YES" to any of the statements below may preclude TXPHP from assisting me:

- This self-report includes a violation of the standard of care as the result of drugs or alcohol. **Yes/No** (select one)
- This self-report includes committing a boundary violation with a patient or a patient's family. **Yes/No** (select one)
- This self-report includes being convicted of, or placed on deferred adjudication, community supervision or deferred disposition for a felony? **Yes/No** (select one)

Section A

Please complete for substance use and/or addiction.

Please list substance of choice and method of ingestion (oral, IV, smoking, intranasal, etc.):

_____

Please list substances that have been used and methods of ingestion (oral, IV, smoking, intranasal, etc.):

_____

_____

Please list approximate dates of intemperate use: _____

The extent of intemperate use for all substances (include info on usage, frequency of use, dosage):

_____

_____

_____

I **have/have not** (select one) been admitted into a treatment facility for substance use. If applicable, here are the details on the treatment facility, dates, and when I completed treatment: _____

_____

I **am/am not** (select one) under current monitoring for substance use. If applicable, here are the details including the name of monitoring entity, date monitoring began, and frequency of testing: _____

_____

I **am/am not** (select one) a member of a mutual assistance group such as AA/NA.

My sobriety date is: _____

Any additional information you feel is important to share with TXPHP: _____

_____

_____

Section B

Please complete for medical conditions, including mental health condition and physical illness.

List all diagnoses, including date each diagnosis was made: _____

_____

_____

Treating physician names and addresses:

_____

_____

My assessment of severity of my condition and a description of any impact on ability to practice within my profession and my specialty:

_____

_____

Dates of any hospitalizations or treatment programs over the past five years and a description of the treatment:

_____

_____

Current treatment for condition (include medications with dosage, therapy, etc.): _____

_____

Any additional information you feel is important to share with TXPHP: _____

_____

_____

_____ _____

Signature Date