

Texas Board of Nursing

333 Guadalupe Street, Suite 3-460, Austin, Texas 78701-3944
(512) 305-6838

Pain Management Evaluator Approval Request Form

All evaluators must be approved by the Board prior to performing an evaluation. Evaluators must meet the criteria specified in the Board's adopted [Guidelines for Physical and Psychological Evaluations](#), which are available on the Board's website. **This form must be completed and submitted along with your curriculum vitae (CV) as well as copies of all professional licenses and certifications.**

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Email: _____
Website: _____
Phone: _____
Fax: _____

1. Is this request related to an evaluation that is pending for a specific individual?
 No.
 Yes. If yes, please provide the individual's full name: _____
2. Have you in the past received Board of Nursing approval to complete this or any other type of evaluation?
 No.
 Yes. If yes, please indicate the types of evaluations: _____
3. Do you hold a current, non-encumbered license in good standing from the appropriate licensing authority in Texas?
 No.
 Yes, I am a medical doctor who is certified in a relevant field of practice by the American Board of Pain Medicine.
 Yes, I am a doctor of osteopathy who is certified in a relevant field of practice by the American Board of Pain Medicine.
4. Are you able to demonstrate training or experience in the evaluation of an individual's fitness to practice?
 No.
 Yes.
5. Do you have at least 10 years of clinical experience in a field of practice relevant to pain management evaluations?
 No.
 Yes.

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6. While the exact tests chosen for administration are within the discretion of the evaluator, a pain management evaluation must include a comprehensive assessment of an individual's underlying disease process and of any substance use or abuse by the individual. Will your pain management evaluation(s) include a review of these items?
- No.
- Yes.
7. Pain management evaluations must address the individual's prognosis, medication regime, the individual's ability to safely practice nursing while taking prescription pain medications, and the regular re-assessment of the individual to ensure compliance with the prescribed medication regime. Will your pain management evaluation(s) include a review of these items?
- No.
- Yes.
8. If approved, do you agree to disclose any adverse action against your occupational license to the Board within five (5) days of the action?
- No.
- Yes.

By completing, signing my name below, and submitting this Evaluator Approval Request Form, I affirm that I am the evaluator identified herein and that the facts set forth in this Evaluator Approval Request Form are accurate and correct to the best of my knowledge.

Evaluator's signature

Date