



TEXAS MEDICAL BOARD

Mailing Address: P.O. Box 2018 • Austin, Texas 78768-2018
Phone 512.305.7010

Physician's Name (Please Print) License Number

THE STATE OF
COUNTY OF

BEFORE ME, the undersigned notary public, on this day personally appeared
who, after being by me duly sworn, upon his oath deposed and said:

- 1. I request that my Texas medical license, License Number, be placed on official retired status.
2. I agree not to practice medicine or engage in clinical activities in this or any other state.
3. I agree that I will not prescribe or administer drugs to anyone, and I will not possess a D.E.A. or Texas controlled substances registration.
4. I agree that I will not apply for licensure by reciprocal endorsement or any other method in any other state based upon my Texas medical license.
5. I understand that as long as I maintain my retired status I will be exempt from payment of the biennial registration fee and the requirement of submitting a biennial registration form.
6. I understand and agree that if I desire to return to active practice, I must first obtain the Board's approval.
7. I understand that if I desire to return to active practice I will be required to provide evidence of my competence at that time, including but not limited to passage of the Special Purpose Examination (SPEX), passage of the Medical Jurisprudence Examination, completion of a mini-residency, and/or passage of a monitored specialty board certification or recertification examination.
8. I understand that any decision by the Board to authorize a return to active practice pursuant to my request will be discretionary at that time.

Physician's Signature Date

SUBSCRIBED & SWORN to me by
day of, 20, to certify which, witness my hand and seal of office.

Notary Public Signature

Notary's Printed Name:
NOTARY SEAL State of

My Commission Expires: