TEXAS MEDICAL BOARD

Military Applicant
Fee Waiver Request Form

Applicant Name:_____
Please print your full name as it will appear on your application

Applicant Address: _____

_____

_____

Applicant Email:_____**SSN#**_____**DOB**_____

Application Type:

❒ Physician *Indicate Physician License Type Below:*

❒ Full (M.D. or D.O.)	❒ Out of State Telemedicine License	❒ Administrative Medicine
❒ Faculty Temporary (FTL)	❒ Physician in Training (PIT)	❒ Provisional License
❒ Physician Public Health	❒ Medical License Limited to Underserved Areas	❒ Conceded Eminence
❒ Visiting Physician Temporary Permit	❒ Visiting Professor Temporary Permit	❒ Military Limited Volunteer

❒ Physician Assistant	❒ Respiratory Care Practitioner	❒ Perfusionist
❒ Acudetox Specialist	❒ Non-certified Radiologic Technician(NCT)	❒ Medical Physicist
❒ Acupuncturist	❒ Medical Radiologic Tech (MRT)	❒ Surgical Assistant

Please check the appropriate box below:

I am a:

❒ **Military Service Member (Active Duty)** ❒ **Military Spouse** ❒ **Military Veteran**

Documentation provided: (***Please provide copies of documentation, no originals***)

- ❒ Copy of passport or birth certificate, which is acceptable as required birth documentation after submission of an application for licensure with our agency; or
- ❒ Copy of State Issued Driver's License, which can ONLY be used as proof of identity for Military Fee Waiver determination

And:

- ❒ DD2-14; ***or***
- ❒ Copy of current original orders, including signature page(s)

Upon receipt of your request with noted documentation, the Licensure Department will evaluate the documentation and provide either a written approval which includes instructions on how to apply or a statement as to why the waiver request is being denied.

Signature (Required)**:** _____ _____

Signature **Date**

Location Address:
333 Guadalupe, Tower 3, Suite 610
Austin, Texas 78701

Mailing Address:
P.O. Box 2029
Austin, Texas 78768-2029

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