



# 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:

<input type="checkbox"/> <b>Physician</b> <i>Indicate Physician License Type Below:</i>		
<input type="checkbox"/> Full (M.D. or D.O.)	<input type="checkbox"/> Out of State Telemedicine License	<input type="checkbox"/> Administrative Medicine
<input type="checkbox"/> Faculty Temporary (FTL)	<input type="checkbox"/> Physician in Training (PIT)	<input type="checkbox"/> Provisional License
<input type="checkbox"/> Physician Public Health	<input type="checkbox"/> Medical License Limited to Underserved Areas	<input type="checkbox"/> Conceded Eminence
<input type="checkbox"/> Visiting Physician Temporary Permit	<input type="checkbox"/> Visiting Professor Temporary Permit	<input type="checkbox"/> Military Limited Volunteer
<input type="checkbox"/> Physician Assistant	<input type="checkbox"/> Respiratory Care Practitioner	<input type="checkbox"/> Perfusionist
<input type="checkbox"/> Acudetox Specialist	<input type="checkbox"/> Non-certified Radiologic Technician (NCT)	<input type="checkbox"/> Medical Physicist
<input type="checkbox"/> Acupuncturist	<input type="checkbox"/> Medical Radiologic Tech (MRT)	<input type="checkbox"/> 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 military ID, passport or birth certificate

And:

- DD-214; **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 a response to include either 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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