TEXAS MEDICAL BOARD

Physician's Name _____ License Number _____
(Please Print)

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, _____, be placed on official emeritus retired status.
   License Number
2. To the best of my knowledge, I have never received a remedial plan or been the subject of disciplinary action by the Texas Medical Board.
3. To the best of my knowledge, I have no criminal history, including pending charges, indictment, conviction and/or deferred adjudication in Texas.
4. To the best of my knowledge, I have never held a license, registration or certification that has been restricted for cause, canceled for cause, suspended for cause, revoked or subject to another form of discipline in a state, or territory of the United States, a province of Canada, a uniformed service of the United States or other regulatory agency.
5. I agree not to practice medicine or engage in clinical activities in this or any other state.
6. I agree that I will not prescribe or administer drugs to anyone, and I will not possess a D.E.A. controlled substances registration.
7. 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.
8. 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.
9. I understand and agree that if I desire to return to active practice, I must first obtain the Board's approval.
10. 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.
11. 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 _____, before me on this the _____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: _____

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