TEXAS MEDICAL BOARD

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

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 hereby request that my Texas medical license, _____, be placed on official Voluntary Charity Care Status.
   License Number
2. I certify that my practice of medicine does not include the provision of medical service for either direct or indirect compensation which has monetary value of any kind.
3. I certify that my practice of medicine is limited to voluntary charity care to indigent populations; in medically underserved areas; or for a disaster relief organization, for which I receive no direct or indirect compensation of any kind for medical service rendered.
4. I certify that my practice of medicine does not include the provision of medical service to my family.
5. I certify that my practice of medicine does not include the self-prescribing of controlled substances or dangerous drugs. All prescribing or administering of controlled substances or dangerous drugs will be in the provision of voluntary charity care only.
6. I acknowledge that in order to qualify for this status I must obtain and report continuing medical education as required under the Medical Practice Act, TEX. OCC. CODE ANN. 156.051-.055 and Board rule 166.2.
7. I understand that in order to qualify for this status I must file a completed registration application with the Texas Medical Board biennially as required under the Medical Practice Act, TEX. OCC. CODE ANN. 156.001-.009.
8. I understand that I must request and execute the Voluntary Charity Care affidavit with each registration.
9. I understand that as a retired physician licensed by the TMB whose only practice is the provision of voluntary charity care as described in (3) above I shall be exempt from the registration fee. I understand that should I return to an active status, I will be required to register and pay the registration fee in force at that time.
10. I understand that I remain subject to disciplinary action under the Medical Practice Act, TEX. OCC. CODE ANN. 164.051-.053, based on unprofessional or dishonorable conduct likely to deceive, defraud, or injure the public if I engage in the compensated practice of medicine, the provision of medical services to members of my family, or the self-prescribing of controlled substances or dangerous drugs.
11. I understand that my attempts to obtain an exemption from the registration under this section by submitting false or misleading statements to the TMB shall render me subject to disciplinary action pursuant to the Medical Practice Act, TEX. OCC. CODE ANN. 164.052(a)(1), in addition to any civil or criminal actions provided for by state or federal law.

_____ _____
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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