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, _____________ (License Number), be placed on official Voluntary Charity Care Status.
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 161.35.
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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