TEXAS PHYSICIAN ASSISTANT BOARD

Physician Assistant'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 physician assistant license, number _____ be placed on official retired status.
2. I agree not to practice as a physician assistant or engage in clinical activities in this or any other state.
3. I agree that I will not prescribe or administer drugs to anyone, and I will not possess a D.E.A. controlled substances registration.
4. I agree that I will not apply for licensure by reciprocal endorsement or any other method in any other state based upon my Texas physician assistant license.
5. I understand that as long as I maintain my retired status I will be exempt from payment of the annual registration fee and the requirement of submitting an annual registration form.
6. I understand and agree that if I desire to return to active practice, I must first obtain the Board's approval.
7. 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 current certification by the National Commission on the Certification of Physician Assistants; completion of specified continuing medical education hours approved for Category 1 credits by a CME sponsor approved by the American Academy of Physician Assistants; limitation and/or exclusion of practice to certain specified activities relating to practice as a physician assistant; remedial education; and/or such other remedial or restrictive conditions or requirements which, in the discretion of the board are necessary to ensure protection of the public and minimal competency of the applicant to safely practice as a physician assistant.
8. 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 Assistant'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: _____

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

Mailing Address
P.O. Box 2029
Austin, Texas 78768-2029
www.tmb.state.tx.us

Phone 512.305.7030
Registration Fax .888. 512.2581
registrations@tmb.state.tx.us