



TEXAS MEDICAL BOARD

REQUEST FOR CANCELLATION OF RESPIRATORY CARE PRACTITIONER LICENSE

Respiratory Care Practitioner's Name _____
(Please print)

Respiratory Care Practitioner Certificate Number _____
(Please print)

BEFORE ME, the undersigned notary public, on this day personally appeared _____,
who, after being by me duly sworn, upon his oath deposed and said:

I hereby request that my respiratory care practitioner certificate number _____ be cancelled effective
immediately.

I understand if my respiratory care practitioner certificate has been expired for one year or longer, my certificate
would be considered canceled, unless an investigation is pending. After closure of the investigation, the certificate
shall be automatically cancelled for nonpayment of registration fees, late fees, and/or failure to timely submit
registration forms.

I understand that by executing this affidavit, my certificate will be cancelled and I will no longer be able to exercise
any rights or privileges as a respiratory care practitioner in Texas.

I understand that in order to practice as a respiratory care practitioner in the future, I must file an application for re-
certification and meet all requirements for certification in effect at the time of application.

Respiratory Care Practitioner's Signature

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