TEXAS MEDICAL BOARD

RETIRED PHYSICIAN APPLICATION TO RETURN TO ACTIVE STATUS - EMERGENCY PROCESSING

Physician Information

Name: _____ Texas license number: _____

Email Address: _____

Telephone Number: _____ Fax Number: _____

Mailing Address: _____

City: _____ St: _____ Zip: _____

Proposed Practice location (if known): _____

City: _____ St: _____ Zip: _____

Intended Type of Practice: _____

_____

Any other State medical licenses held: _____

_____

_____

_____

_____

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

Mailing Address:
P.O. Box 2029 MC 245
Austin, Texas 78768-2029
www.tmb.state.tx.us

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