Texas Medical Board
MAILING ADDRESS: P.O. BOX 2029 • AUSTIN TX 78768-2029
Phone: (512) 305-7010

CANCELLATION BY REQUEST

Physician's Name _____ License 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 request that my Texas Medical License, Number _____ be cancelled immediately.
License Number

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

I understand that in order to practice medicine again in Texas following cancellation, I must file an application for relicensure and meet all requirements for licensure in effect at the time of application.

_____ _____
Physician's Signature Date

SUBSCRIBED & SWORN to before me by _____, 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 TX 78701
WEB SITE ADDRESS: www.tmb.state.tx.us