



# TEXAS DEPARTMENT OF LICENSING & REGULATION

P.O. Box 12157 • Austin, Texas 78711-2157

[www.tdlr.texas.gov](http://www.tdlr.texas.gov)



## DOCTOR OF PODIATRIC MEDICINE LICENSE INACTIVE STATUS REQUEST FORM

Name:

License Number:

\_\_\_\_\_  
Last

\_\_\_\_\_  
First

\_\_\_\_\_  
Middle

1. I hereby request that my Doctor of Podiatric Medicine license be placed on Official Inactive Status.

**Reason for request:**

2. I understand that in accordance with Texas Occupations Code §51.4011 and 16 Texas Administrative Code §130.46 a licensee may place a license on Inactive Status by applying for Inactive Status on a form prescribed by the Department before the license expiration date.
3. I understand, in addition to this form, I must complete the license renewal form, other than the continuing medical education (CME) requirements and pay the required license renewal fee.
4. I understand, in order to maintain my license, I must renew the unexpired license before the expiration date.
5. I understand, in order to remain on Inactive Status, I must complete the Inactive Status request form with each renewal.
6. I understand failure to renew an Inactive Status license will result in the expiration of my license.
7. I understand I may not practice podiatric medicine in this state while on Inactive Status. The practice of podiatric medicine by a holder of a license that is on Inactive Status constitutes the practice of podiatric medicine without a license which is a criminal offense.
8. I understand that any attempt to obtain Inactive Status by submitting false or misleading statements to the Department shall render me subject to disciplinary action pursuant to the Podiatric Medical Practice Act and Department rules, in addition to any civil or criminal actions provided for by state or federal law and Department rule.
9. I understand in order to return to an Active Status, I must notify the Department in writing of the effective date and I must have completed the CME that is required under the Podiatric Medical Practice Act during the preceding license period.

### STATEMENT OF APPLICANT

I certify that I will comply with all applicable laws and rules related to my Doctor of Podiatric Medicine license. I further certify that all information I have provided is true and correct. I understand that providing false information may result in denial of this application and/or revocation of the license.

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Signature of Applicant