Texas Physician Health Program

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Practice and/or Prescribing Restrictions Report

CEASE PRESCRIBING

During the past three months, I have not prescribed any medication, including for myself, or for family members. _____ (initials)

TEMPORARILY STOP PRACTICE

During the past three months, I have not practiced medicine and I agree that I will seek permission from TXPHP prior to resuming practice. _____ (initials)

LIMIT PRACTICE

During the last three months, I have limited my practice as required by TXPHP to:

_____

_____

_____

_____

REPORT DATE: _____ March 15
_____ June 15
_____ September 15
_____ December 15

By my signature, I certify that the above representations are true and correct and that I understand and agree that my failure to comply with my original restrictions or to accurately report the required information may result in referral to the Texas Medical Board.

_____ _____

PRINT NAME SIGNATURE DATE