



RETIREMENT REQUEST FORM (DENTISTS AND DENTAL HYGIENISTS)

Texas State Board of Dental Examiners

333 Guadalupe, Tower 3, Suite 800

Austin, TX 78701-3942

Phone: (512) 463-6400

Fax: (512) 463-7452

Website: www.tsbde.texas.gov

INSTRUCTIONS

1. A licensee may request this application to retire their license up to 60 days prior to their intended retirement date.
2. A request for retirement is subject to the license being current and in good standing. Once retirement status is granted, annual licensure fees and continuing education requirements are waived for the period the license is in retirement.
3. Prescription writing privileges with DEA and DPS may not be maintained during retired status.
4. Anesthesia permits issued to dentists will be removed from the license.
5. A licensee on retired status may not perform any activity regulated under the Occupations Code.
6. Your license will be retired on the retirement effective date you provide below. You will receive a letter in the mail confirming your license retirement.

LICENSEE INFORMATION

_____ DDS _____ RDH _____
 LICENSEE NAME TODAY'S DATE

 MAILING ADDRESS CITY STATE ZIP

 PHONE NUMBER E-MAIL ADDRESS

 TEXAS LICENSE NUMBER LICENSE EXPIRATION DATE PREFERRED RETIREMENT EFFECTIVE DATE

READ AND SIGN BELOW:

I am no longer practicing in Texas and request that the Texas State Board of Dental Examiners (TSBDE) place my license in retired status. I understand that upon a request for reactivation I must be in compliance with all applicable laws and rules at that time, and must obtain TSBDE approval.

SIGNATURE OF LICENSEE

ATTENTION DENTISTS:

Refer to TSBDE Rule 108.8 (Records of the Dentist) for complete details on retention of patient records and/or the transfer of patient records. Dentists are required to report to the TSBDE the disposition of patient records within 15 days of a transfer. Failure to notify the TSBDE of a transfer of dental records will result in an incomplete request for retirement of the license. **The disposition of my dental records is as follows:**

Records Maintenance/Location: If you are retiring your license and will be storing your patient records.

 ADDRESS WHERE RECORDS ARE STORED CITY STATE ZIP CODE

OR

Transfer of Records Agreement: If you have entered into a written transfer of records agreement, provide the name and contact information for the Texas licensed dentist who has assumed responsibility for those patient records:

 NAME OF DENTIST RECORDS WERE TRANSFERRED TO TEXAS DENTAL LICENSE NUMBER

 ADDRESS WHERE PATIENT RECORDS ARE MAINTAINED CITY STATE ZIP CODE