



# 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:

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**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