



**STATE OF MISSOURI**  
 DIVISION OF PROFESSIONAL REGISTRATION  
 STATE BOARD OF PODIATRIC MEDICINE  
**RETIRED PODIATRIC MEDICINE LICENSE AFFIDAVIT**

STATE BOARD OF PODIATRIC MEDICINE  
 P.O. BOX 423, 3605 MISSOURI BOULEVARD  
 JEFFERSON CITY, MISSOURI 65102-0423  
 TELEPHONE (573) 751-0873  
 TTY: (800) 735-2966  
 WEBSITE: <http://pr.mo.gov/podiatrists>  
 EMAIL: [podiatry@pr.mo.gov](mailto:podiatry@pr.mo.gov)

**PLEASE COMPLETE AND RETURN THIS FORM TO THE ADDRESS LISTED ABOVE.**

# AFFIDAVIT

I, \_\_\_\_\_, hereby certify that as  
(PLEASE PRINT NAME)  
 of \_\_\_\_\_ I wish to place my Missouri podiatric medicine license number  
(DATE OF RETIREMENT)  
 \_\_\_\_\_ on a retired status.

I further certify that I will not practice the profession of podiatric medicine in the state of Missouri pursuant to chapter 330.

If at anytime in the future I should desire to re-engage in the practice of podiatric medicine, I will register with the board as provided by this chapter.

CURRENT MAILING ADDRESS		E-MAIL ADDRESS (OPTIONAL)
CITY	STATE	ZIP CODE

<b>MUST BE SIGNED IN PRESENCE OF NOTARY ▶</b>		LICENSEE SIGNATURE
STATE OF	COUNTY	NOTARY PUBLIC EMBOSSED SEAL OR BLACK INK RUBBER STAMP
SUBSCRIBED AND SWORN BEFORE ME, THIS DAY OF _____ 20____		
<b>USE RUBBER STAMP IN CLEAR AREA BELOW</b>		
NOTARY PUBLIC SIGNATURE	MY COMMISSION EXPIRES	
NOTARY PUBLIC NAME (TYPED OR PRINTED)		