Butler County Medical Society

7249 Liberty Way Suite 200
West Chester, Ohio 45069
info@butlercountymedicalsociety.org

PHYSICIAN RETIREMENT FORM

Name_____

Office Address_____

Future Mailing Address_____

Future Telephone_____**E-mail address:**_____

How may patients obtain records?_____

_____

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_____

I, _____, M.D., hereby, notify the Butler County Medical Society of my retirement and closing of my office effective and request retired active membership.

Signed_____ **Date**_____