Application for
Replacement/New Wall Certificate
Alabama Medical License

License Number: _____

Name: _____

Mailing Address: _____

City: _____ State: Alabama Zip: _____

License Lost ☐

License Destroyed ☐

(A notarized affidavit must accompany this application as to how and when the license was lost or destroyed.)

Name Change ☐

Change Due to: _____

(Marriage, Divorce, Court Order, etc.)

(A copy of the legal document verifying name change must be submitted with this application.)

FEE: $25.00

Signature: _____

Date: _____

Please submit this application along with affidavit and fee and to the following address:

Medical Licensure Commission
Post Office Box 887
Montgomery, Alabama 36101-0887

Print Form