

STATE OF ALABAMA
MEDICAL LICENSURE COMMISSION
POST OFFICE BOX 887
MONTGOMERY, ALABAMA 36101-0887

TELEPHONE
(334) 242-4153

RETIRED SENIOR VOLUNTEER PROGRAM
APPLICATION FOR RESTRICTED LICENSE TO PRACTICE
MEDICINE/OSTEOPATHY

NAME IN FULL: _____
(Last Name) (First Name) (Middle Name)

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

COUNTY: _____ TELEPHONE: (_____) _____

TYPE OF PRACTICE: _____

PRACTICE ADDRESS: _____
Name of free medical clinic or non-profit facility

CITY: _____ STATE: _____ ZIP CODE: _____

COUNTY: _____ TELEPHONE: (_____) _____

DATE: _____ SIGNATURE: _____

Please specify the following:

Mailing Address: Home Practice

NO FEE REQUIRED

For Office Use Only:

Board Agenda - Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec