ALABAMA STATE BOARD OF MEDICAL EXAMINERS

Physician Assistant/Anesthesiologist Assistant Registration Termination Request Form

* indicates a required field

Physician's information

Physician's name: *

License number: *

Physician's practice address

Street address: *

Additional address:

City: *

State: *

Zip Code: *

PA/AA information

PA/AA's name: *

License number: *

PA/AA's practice address

Street address: *

Additional address:

City: *

State: *

Zip Code: *

PA/AA ceased providing services under the registration agreement on date (mm/dd/yyyy): *

Reason for termination: *

Submitting person's name: *

Your email address: *

Confirm email address: *

Please note: The physician assistant and the physician shall each inform the Board in writing of the effective date of the termination of employment and the reason for such termination. The Board cannot accept a termination request from anyone other than the physician assistant or physician.

This form should be emailed to kbuley@albme.org once complete.

Rev. 09/30/2020