ALABAMA BOARD OF MEDICAL EXAMINERS
P. O. Box 946 – Montgomery, Alabama 36101 • 848 Washington Avenue – 36104

Application for Alabama Pain Management Registration

****Separate registration required for each location where pain management services are provided****

Name: ____________________________________ AL License #: _______________________

Address: ________________ _______________________ ___________ ___________
Street City State Zip

Telephone: ____________________ Fax: _________________________ Email: ___________

DEA Number: _______________________ DEA Expiration Date: ______________________

1. Are you registered with PDMP? [ ] Yes [ ] No
   (Attach copy of PDMP registration receipt)
2. Have you ever had a controlled substance registration certificate denied, restricted or disciplined? [ ] Yes [ ] No
   If yes, the attach a summary of each action including the year, state and description of each action.
3. Have you ever had a disciplinary action taken against your medical license in Alabama or any other state? [ ] Yes [ ] No
   If yes, attach an explanation of the action, including the year, state and description of each action.

Please provide the following information for the above location where you provide pain management services: (Attach additional pages if necessary)

Facility Name: ____

Physical Address:____
Street City State Zip

Owners, Co-Owners, Operators: ____

Full Name of Medical Director: ____

Full names of all physicians providing pain management services at this location:

_____________________________________ _____________________________________

_____________________________________ _____________________________________

_____________________________________ _____________________________________

I swear (affirm) that the information set forth on this application for Alabama Pain Management Registration form is true and correct to the best of my knowledge, information and belief. I also understand that the Board of Medical Examiners may conduct an on-site inspection of my records at any time.

Signature of Physician: ______________________________ Date: _________________

Registration Fees: $100.00 for first location; no additional charge for each additional location