ALABAMA MEDICAL LICENSURE COMMISSION

POST OFFICE BOX 887
MONTGOMERY, AL 36101-0887

Telephone
334-242-4153

Email
mlc@almlc.org

APPLICATION FOR LICENSE TO PRACTICE MEDICINE

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

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

COUNTY: _____ TELEPHONE: (_____) _____

TYPE OF PRACTICE: _____

PRACTICE ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

COUNTY: _____ TELEPHONE: (_____) _____

EMAIL ADDRESS: _____

DATE: _____ SIGNATURE: _____

I understand and agree that by typing my name, I am providing an electronic signature that has the same legal effect as a written signature pursuant to Ala. Code §§ 8-1A-2 and 8-1A-7. I attest that the foregoing information has been provided by me and is true and correct to the best of my knowledge, information and belief.

SPECIFY ONE: MD/DO/L License

Please Specify One:

Public Address:	☐ Home Address	☐ Practice Address
Mailing Address:	☐ Home Address	☐ Practice Address

LICENSE FEE $75.00
MAKE CHECK PAYABLE TO MEDICAL LICENSURE COMMISSION OF ALABAMA OR PAY ONLINE AT ALBME.ORG

Rule 540-X-3-.23, effective August 30, 1999 states that "a certificate of qualification issued by the Board shall be withdrawn by the Board after a period of six (6) months from the date of issuance unless the applicant has filed an application for a license to practice medicine with the Medical Licensure Commission of Alabama and paid the required fee.

Please notify the Commission within 15 days of a change of address.

For Office Use Only: Board Agenda – Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec