MARYLAND BOARD OF PHYSICIANS

P.O. BOX 37217, BALTIMORE, MD 21297
410-764-4705; 1-800-492-6836, ext 4705

FOR BANK USE ONLY

DATE: _____/_____/_____

CHECK NUMBER: _____

AMT PAID: $_____

NAME CODE: _____

APPID: 50

APPLICATION FOR ALLIED HEALTH REPLACEMENT LICENSE AND WALL CERTIFICATE

Instructions:

1. Complete this application including notary.
2. Replacement requested for **(circle one or both)**:
   a. License (fee $25) b. Wall Certificate (fee $75)
3. Include your check or money order payable to the Maryland Board of Physicians.
4. Reason replacement is requested **(circle one)**:
   a. Lost b. Never Received c. Destroyed/Damaged d. Stolen e. Name Misspelled
5. Mail completed application and fee to address at the top of this form.

If you have RENEWED your license within the last 24 months and need to print a copy of your license, STOP!
DO NOT submit this form. Go to our website and select Print My License to download your license.

License Number

Social Security Number (For identification purposes only) -- --

Last Name and Generational Indicator (Jr., III. etc)

First Name and Middle Name/ Initial

Address (Apartment Number, Suite Number or C/O)

Address (Street Address)

City

State

Zipcode

Date of Birth -- --

Telephone Number

Email Address:_____

I solemnly affirm under the penalties of perjury that the contents of the foregoing paper are true and correct to the best of my knowledge, information and belief.

Signature:_____

Date: _____/_____/_____

This Form MUST Be Notarized

Notary Public

Date: _____/_____/_____

City/County of Residence:_____

Commission Expires: _____/_____/_____

Notary Signature: _____