MARYLAND BOARD OF PHYSICIANS
P.O. BOX 37217, BALTIMORE, MD 21297
410-764-4705; 1-800-492-6836, ext 4705
www.mbp.state.md.us

FOR BANK USE ONLY

DATE: ____/____/_____

CHECK NUMBER: _____

AMT PAID: $_____

NAME CODE: _____

APPID: 50 Fees: $25

APPLICATION FOR ALLIED HEALTH REPLACEMENT LICENSE

Instructions:

1. Complete this application including notary.
2. Include your check or money order for $25 payable to the Maryland Board of Physicians. Mail the completed application and fee to the address at the top of this page.
3. Reason replacement is requested (check one). *If selecting c or d, return the license with the application*:
   a. ☐ Lost b. ☐ Never Received c. ☐ Destroyed/Damaged d. ☐ Name Misspelled
4. In lieu of mailing a license, the Board will send you an email containing a link to print a digital copy of your license. Please provide a valid email address* in the space below.

If you have RENEWED your license within the last 24 months and need a copy of your license, STOP! DO NOT submit this form. Go to the Board's website at www.mbp.state.md.us and select Allied Health—Print My Renewed License/Receipt 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

Zip code

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: _____