

FOR BANK USE ONLY

DATE: ____/____/____
CHECK NUMBER: _____
AMT PAID: \$ _____
NAME CODE: _____
APPID: 41 Fees: \$25

APPLICATION FOR PHYSICIAN REPLACEMENT LICENSE

Instructions:

1. Complete this application including notary. Attach a passport quality photo taken within 60 days of the application to the back of this application.
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 **Physician—Print My Renewed License/Receipt** to download your license.

License Number Social Security Number (For identification purposes only)

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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

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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

Affix passport quality photo, taken within 60 days of the application, to back of this application. The Board will not accept a copy of a photo.

Notary Public

Date: ____/____/____

City/County of Residence: _____

Commission Expires: ____/____/____

Notary Signature: _____