

**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: 41 Fee: \$25

**APPLICATION FOR PHYSICIAN  
REPLACEMENT LICENSE**

**Instructions:**

1. Complete this application including notary. Attach passport quality photo to the back of this application.
2. Include your check or money order for \$25.00 payable to the Maryland Board of Physicians. Mail completed application and fee to address at the top of this page.
3. Reason replacement is requested (circle one). *If selecting c or d, return license with application:*
  - a. Lost
  - b. Never Received
  - c. Destroyed/Damaged
  - d. Name Misspelled

**If you have RENEWED your license within the last 24 months and need a copy of your license, STOP! DO NOT submit this form. The Board no longer mails renewed licenses to licensees. Go to the Board’s website by clicking on or copying and pasting this link: [https://www.mbp.state.md.us/licensure\\_phyrenewals.aspx#5b](https://www.mbp.state.md.us/licensure_phyrenewals.aspx#5b)**

License Number

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Social Security Number (For identification purposes only)

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

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First Name and Middle Name/ Initial

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

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Address (Street Address)

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City

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State

--	--

Zip code

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Date of Birth

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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 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: \_\_\_\_\_