



# ALABAMA STATE BOARD OF MEDICAL EXAMINERS

LARRY D. DIXON, EXECUTIVE DIRECTOR

P.O. BOX 946  
MONTGOMERY, ALABAMA 36101-0946

TELEPHONE  
(334) 242-4116

## Dispensing Physician's Registration Form

Physician Name: \_\_\_\_\_ LIC. # \_\_\_\_\_

Primary practice location: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone No. \_\_\_\_\_

DEA No. \_\_\_\_\_ Expiration date \_\_\_\_\_

**Additional practice location:** \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone No. \_\_\_\_\_

DEA No. \_\_\_\_\_ Expiration Date \_\_\_\_\_

**Additional practice location:** \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone No. \_\_\_\_\_

DEA No. \_\_\_\_\_ Expiration Date \_\_\_\_\_

**Additional practice location:** \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone No. \_\_\_\_\_

DEA No. \_\_\_\_\_ Expiration Date \_\_\_\_\_

**Additional practice location:** \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone No. \_\_\_\_\_

DEA No. \_\_\_\_\_ Expiration Date \_\_\_\_\_

Completed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

I hereby certify the foregoing information to be correct to the best of my knowledge, information and belief.

\_\_\_\_\_  
Physician/Osteopath Signature

**NOTE: The rules of the Board of Medical Examiners require that a new registration form be filed when there is any change in the registrants' principal or additional practice locations.**