STATE OF ALABAMA
MEDICAL LICENSURE COMMISSION
POST OFFICE BOX 887
MONTGOMERY, ALABAMA 36101-0887

RETIRED SENIOR VOLUNTEER PROGRAM
APPLICATION FOR LIMITED LICENSE TO PRACTICE MEDICINE

NAME IN FULL: _____
(Last Name) (First Name) (Middle Name)

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

COUNTY: _____ TELEPHONE: (_____) _____

TYPE OF PRACTICE: _____

PRACTICE ADDRESS: _____
Name of free medical clinic or non-profit facility

_____

CITY: _____ STATE: _____ ZIP CODE: _____

COUNTY: _____ TELEPHONE: (_____) _____

DATE: _____ SIGNATURE: _____

Please specify the following:
Mailing Address: ☐ Home ☐ Practice

NO FEE REQUIRED

For Office Use Only:
Board Agenda - Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec