ALABAMA BOARD OF MEDICAL EXAMINERS
P.O. Box 946 / Montgomery, AL 36101-0946 / (334) 242-4116

PHYSICIAN ASSISTANT/ ANESTHESIOLOGIST ASSISTANT APPLICATION FOR NAME CHANGE

License # _____

Name changed from: _____

Name changed to: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Change due to: _____

(Marriage, Divorce, Court Order, etc.)

I understand and agree that by typing my name, I am providing an electronic signature that has the same legal effect as a written signature pursuant to Ala. Code §§ 8-1A-2 and 8-1A-7. I attest that the foregoing information has been provided by me and is true and correct to the best of my knowledge, information and belief.

_____ _____

Signature of Assistant to Physician Date

Please submit a completed application to:

APPDept@albme.gov

OR

Mail to:

Alabama Board of Medical Examiners
ATTN: APP Department
848 Washington Avenue
Montgomery, AL 36104