Please Print this form on the Clinic or Facility letterhead.
NOTE: This text will not print.

CERTIFICATION

DATE:_____

TO: State Board of Medical Examiners

This is to certify that _____, M.D./D.O. has agreed to perform no fewer than 100 hours of voluntary professional services annually at the _____, located at _____,
(Clinic Name)
Alabama, which is an established free medical clinic operating under the provisions of Ala. Code §6-5-660 and provides outpatient medical care to patients unable to pay for it.

_____
Clinic or Facility Administrator

_____
Address

_____
City State Zip

_____
Telephone

_____
Facsimile

Print Form