ALABAMA STATE BOARD OF MEDICAL EXAMINERS

Certification of Institution

Institution	
Specialty	
Accreditation	

This is to certify that the individuals listed below are making applications to renew a limited certificate of qualification at the institution listed above.

	License No.	Last, First Name	Post-Grad Year	R/F/DP/VP/SP/SI
1.				
2.				
3.				
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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 8-14-7. 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.

_____

Name of Dean-School of Medicine OR Director-Residency Training Program OR Warden/Medical Director OR Chief Medical Officer

_____ _____

Signature of Dean-School of Medicine OR Director-Residency Training Program OR Warden/Medical Director OR Chief Medical Officer — Date

Please submit a completed certification to: Credentialing@albme.gov