(Letterhead)

CERTIFICATION OF FREE CLINIC

DATE:_____

TO: State Board of Medical Examiners

This is to certify that _____, M.D./D.O. has agreed to perform voluntary professional services annually at the _____,

located at _____, Alabama, which is an established free medical clinic operating under the
(Clinic Name)
provisions of Ala. Code §6-5-662* that provides outpatient medical care to patients unable to pay for it.

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.

_____
Clinic or Facility Administrator

_____
Address

_____

_____
Telephone

_____
Email Address

*Or other nonprofit organization or facility located in Alabama which is approved by the Board and which provides outpatient medical care to individuals unable to pay for the care. A copy of the Board's approval must be attached.