

REPLACEMENT OF CLINIC PERMIT FORM

9/26/2024

PLEASE TYPE OR PRINT

NAME AS IT APPEARS ON ORIGINAL PERMIT

PERMIT NUMBER

ORIGINAL DATE OF ISSUE

MAILING ADDRESS

CITY

STATE

ZIP CODE

1. The replacement of this permit is due to a name change, loss, or destruction.

(circle one)

2. If due to a loss of destruction, please state the facts.

3. If due to a name change, type or print the clinic name as your wish it to appear on the replacement permit. Enclose copy of official document indicating name change (i.e. court document).

****You must return the original permit with this form for the application to be processed. If the original was destroyed, you must include a letter stating this fact.**

I solemnly swear or attest that the statements herein are true and accurate to the best of my knowledge.

SIGNATURE OF OWNER

Sworn to before me this _____ day of _____, 20 ____ .

NOTARY PUBLIC SIGNATURE AND SEAL

EXPIRATION DATE

Return application and fee of \$90 to:

**ALABAMA STATE BOARD OF CHIROPRACTIC EXAMINERS
126 CHILTON PLACE
CLANTON, AL 35046**