

REPLACEMENT/DUPLICATE
LICENSE APPLICATION FORM

9/26/24

PLEASE TYPE OR PRINT

NAME AS IT APPEARS ON ORIGINAL LICENSE

LICENSE NUMBER

ORIGINAL DATE OF ISSUE

MAILING ADDRESS

CITY

STATE

ZIP CODE

1. The replacement of this license is due to a name change, loss, or destruction. (Circle one) If due to a name change please mail the original with this form.
2. If application is a request for duplicate please indicate reason for duplicate below.
3. If due to a loss or destruction, please state the facts:

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

D. C.

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

SIGNATURE OF APPLICANT

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 35045