REPLACEMENT OF CLINIC PERMIT FORM

4/2025

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
1700 YELLOWLEAF ROAD
CLANTON, AL 35045