



Alabama State Board of Respiratory Therapy

P. O. Box 241386, Montgomery, AL 36124-1386

Phone: 334-215-7233

CHANGE OF INFORMATION NOTICE

Current Licensee Information on file:

Last Name: _____ First Name: _____ Middle Name: _____

AL Respiratory Therapy License #: _____

Mailing Address: _____ City/State _____ County _____ Zip _____

Physical Address: _____ City/State _____ County _____ Zip _____

(If a P.O. Box is listed as your mailing address)

Home Phone: (____) ____-____ Work Phone: (____) ____-____ Other Phone: (____) ____-____

E-mail: _____

Complete ALL sections below that have changed.

Last Name: _____ First Name: _____ Middle Name: _____

Mailing Address: _____ City/State _____ County _____ Zip _____

Physical Address: _____ City _____ County _____ Zip _____

(If a P.O. Box is listed as your mailing address)

Home Phone: (____) ____-____ Work Phone: (____) ____-____ Other Phone: (____) ____-____

E-mail: _____

Employment:

Table with 4 columns: Name and Address of Employer, Beginning/Ending dates of Employment, Title of Position, Phone

If additional space is needed, record on a separate sheet of paper and attached to this application.

Education:

Table with 5 columns: Education Level, City, State, Dates Attended, Graduation date, Major

If additional space is needed, record on a separate sheet of paper and attached to this application.

List all Respiratory Therapy and other health-related license you hold or have held.

Table with 4 columns: State, Type License, Date License was Issued, License Status (Active/Inactive)

If additional space is needed, record on a separate sheet of paper and attached to this application.

