Commonwealth of Massachusetts

BOARD OF REGISTRATION IN MEDICINE
560 Harrison Avenue, G-4
Boston, MA 02118 – (617) 654-9810 www.massmedboard.org

REQUEST FOR REPLACEMENT WALL CERTIFICATE

Please enclose a personal check or money order for $27.00, made payable to the *Commonwealth of Massachusetts*.

Please explain the reason for requesting a replacement wall certificate

_____

_____

I declare under the pains and penalties of perjury that my statements are true and correct.

_____ _____/____/_____
Signature Month Day Year

_____ MA. LICENSE #: _____
Print name

_____
Mailing address

_____ _____ _____
City State Zip Code

Please forward this completed form with your check for $27.00 to the Board of Registration in Medicine at the above listed address. Thank you.

For Office use only

Date Received: _____/_____/_____ Date Completed: ____/____/____

Completed by: _____