REQUEST FOR DUPLICATE WALL LICENSE

I, _____, M.D., being first duly sworn, dispose and say that I was born in _____ on _____; that I obtained the degree of doctor of medicine from _____ at _____ in the year _____, and that I am the physician who was licensed by the West Virginia Board of Medicine to practice medicine and surgery in the State of West Virginia under the name of _____ on the _____ day of _____, _____, and received Certificate of License Number _____.

I further certify that the above-mentioned certificate has been lost or destroyed.

Physician's signature:_____

Current Mailing Address:_____

_____ Phone Number:_____

Subscribed and sworn to before me this _____ day of _____, _____.

NOTARY SEAL

_____
(Signature of Notary Public)

My Commission expires _____.

Revised 8/07