City of Springfield

Physician Registration Form

I, the undersigned, herewith present Medical License # _____ for the records of the Office of the City Clerk. I intend to conduct the practice of medicine in the City of Springfield.

My office or usual place of business _____
(Street Name)

_____
(City) (State) (Zip Code)

_____ **I AM EXEMPT FROM FILING BECAUSE I AM NOT ENGAGED IN THE PRACTICE OF MEDICINE IN THE CITY OF SPRINGFIELD.**

The required fee of $100.00 is herewith tendered.

I hereby Certify under the Penalties of Perjury that all information on this Application is true under authority of the laws of the Commonwealth and the City of Springfield.

Signature _____ Date _____

Print Name _____

**** FOR ADMINISTERATIVE USE ONLY ****

Springfield, Massachusetts Date _____

In accordance with the provisions of Chapter 112, Section 8 of the Massachusetts General Laws, I hereby certify that Dr. _____
Has this day exhibited certificate or certificate statement #_____ issued Under the authority of the laws of the Commonwealth and the City of Springfield.

The required fee of $100.00 has been paid.

Signed _____Clerk of the City of Springfield.
Wayman Lee