Alabama Board of Home Medical Equipment
P. O. Box 240636, Montgomery, AL 36124
Phone: 334-215-3474 FAX: 334.215.3457
Web Site: www.homemed.alabama.gov

APPLICATION FOR CHANGE OF ADDRESS

Instructions:

- **This form is to be completed for existing licensees who are requesting a change of address only.**
- **If additional changes such as equipment provided, FEIN or SSN, or disciplinary actions have ensued,**

here. You will need to complete a new application instead.

- **Once this completed form is received in the Board Office, you will be contacted by an Inspector for the Board to schedule your site inspection. The site inspection form and 21 Supplier Standards are published at www.homemed.alabama.gov for your convenience.**

Current License Number: _____

Applicant Information

(Instructions: Please list below the new address and information)

Legal Business Name: _____
(D.B.A., Trade, or Business Name)
Street Address: _____

City, State, Zip Code: _____

Phone: (____)_____ FAX: (____)_____

E-mail Address: _____

Preferred Mailing Address (for mailing purposes only):

_____

City, State, Zip Code: _____

FEIN# or SS#: _____ Date Business Started: __/__/____

☐ Yes ☐ No Are patient records stored at this location?

If "No", where are they kept?

_____

_____

_____

_____

Instructions: All business licenses and occupational licenses are required to reflect the new physical address. List all business and occupational licenses you hold below (i.e. city, county or state business license, pharmacy license if supplying oxygen, Elevator Permit if supplying stair lifts, Orthotics and Prosthetics License (if supplying custom made O & P):

State/County/City	Type License	Date License Expires	Is the new address reflected on this license?
			□ Yes □ No
			□ Yes □ No
			□ Yes □ No
			□ Yes □ No
			□ Yes □ No
			□ Yes □ No

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

General Liability Insurance

Instructions: General Liability Insurance Policy must reflect the new physical address.

Insurance Company Name: _____

Policy Number: _____ Date Issued: _____

Expiration Date: _____ Agent Name: _____

Agent Phone #: _____ Agent FAX: _____

- □ I have attached a copy of all business and occupational licenses reflecting new address;
- □ I have attached a copy of certificate of coverage for general liability insurance (minimum of $300,000) reflecting new address;
- □ I have attached $275 for the Site Inspection Fee upon Change of Physical location.
- □ Location is ready for site inspection now
  OR
  Location will be ready for site inspection after ___/___/_____.
  (licensees are to file a change of address notice 30 days prior or 30 days after move.)

Affidavit of Applicant

I, _____ acknowledge and state that all of the information supplied in this application is true and correct to the best of my knowledge, and that I have read and are familiar with the Rules and Regulations pertaining to the licensure of Home Medical Equipment in the State of Alabama. I acknowledge that any false or untrue statements or representation made in this application may result in the revocation or denial of any license to provide home medical equipment granted to me and/or criminal prosecution to the fullest extent of the law.

_____ _____

Person in Charge Signature Date