APPEALS REQUEST

Please email the completed form to info@mdcb.org.

☐ Lapsed CE Appeal ☐ Lapsed Payment Appeal ☐ Temporarily Disabled Appeal*

Date: _____

Name: _____ MDCB #: _____

Address: _____

City: _____ State: _____ Zip: _____

E-mail: _____ Phone: _____

I understand it is the professional responsibility, as outlined on the MDCB website, for each CMD to maintain current contact information on file with the MDCB, submit the renewal fee by December 31st of each calendar year and complete and submit 50 continuing education in each five-year cycle. ☐

I have read, understand and agree to the policy (https://www.mdcb.org/cmd-credentialing) for which I am appealing. ☐

Brief explanation of reason for request for appeal: _____

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*Requests for temporarily disabled status must be accompanied by signed documentation from a licensed physician.