

**Prescribing Provider Certification of Controlled Substance**

To the Alabama Physician Health Program:

I, \_\_\_\_\_, the prescribing provider for \_\_\_\_\_,  
Patient's Name

currently treating patient for \_\_\_\_\_ and prescribing \_\_\_\_\_

for said treatment, certify that I am aware that he/she is being monitored by the APHP.

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Signature Date

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