



**MEDICAL BOARD OF CALIFORNIA**  
Licensing Program



**CHANGE OF ADDRESS FORM**

Please fax to (916) 263-2944 or mail to  
Medical Board of California, at the below address.  
**PLEASE PRINT ALL INFORMATION CLEARLY.**

**LICENSE/REGISTRATION NUMBER:**

**NAME:**

LAST

FIRST

(FULL) MIDDLE

**PREVIOUS ADDRESS OF RECORD:**

CITY

STATE

ZIP

COUNTRY

Please allow only 30 characters per line for your Address of Record.

**PLEASE CHANGE MY ADDRESS OF RECORD TO:**

Note: Pursuant to Business and Professions Code Section 2021(a)(b), the Address of Record is public information and will be posted in the licensee's profile on the Medical Board's Web site.

CITY

STATE

ZIP

COUNTRY

**IF THE ADDRESS OF RECORD IS A POST OFFICE BOX, A CONFIDENTIAL STREET ADDRESS MUST ALSO BE REPORTED:**

**NOTE:** The street address of a private mail box service may not be used as a confidential street address.

CITY

STATE

ZIP

COUNTRY

**TELEPHONE NUMBER:** (PLEASE INCLUDE AREA CODE)

(The telephone number is not public information. It will only be used if there are questions regarding your request.)

\_\_\_\_\_  
**SIGNATURE & DATE**