

Oregon Medical Board
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ADDRESS CHANGE FORM

Plain Language Improvements:

- Revised for standardization between all forms
- User friendly content layout
- Legible format

Licensee Name: _____

PREFERRED MAILING ADDRESS: PRACTICE;

PRACTICE & MAILING ADDRESSES ARE PUBLIC INFORMATION.

Do you want your practice address posted on the Board's Website? Yes; No

Effective Date of this address change: _____

**PHYSICAL
PRACTICE/TRAINING
LOCATION (Business Name):** _____

Practice address is **REQUIRED** to maintain an Active status. Your residence address will be used as your practice address if no practice address is designated.

Street Address Only

* (PO Box Address below): _____

City: _____ State: _____ Zip: _____

Telephone: _____ Oregon County: _____

Email Address: _____ Fax #: _____

RESIDENCE ADDRESS: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Cell Ph: _____

* **OTHER ADDRESS**

(If different from either address entered above): _____

Street or PO Box: _____

City: _____ State: _____ Zip: _____

Telephone: _____

LOCATION OF FORMER OREGON PATIENTS' RECORDS:

Address: _____

Telephone: _____ Effective Date: _____

Signature: _____ Date: _____

Change of Address information cannot be processed without your signature.

Please complete all information, and mail or fax to the Oregon Board.

After

Web Form 10/08