

# OREGON BOARD OF OPTOMETRY

## CHANGE OF ADDRESS NOTIFICATION

Licensee Name: \_\_\_\_\_ License Number: \_\_\_\_\_

PRACTICE LOCATION Change of Primary ____ Change or New Additional Location* ____			ADDRESS OF RECORD - all mail from Board (If other than your practice location)		
	OLD LOCATION ** <small>** If terminating a location, notify the Board about your patient record custody below.</small>	NEW LOCATION		OLD	NEW
Business Name			Street Address		
Street Address			City, State, Zip		
City, State, Zip			<b>Patient Records in custody of Oregon licensed optometrist named:</b>		
Phone Number:			Phone Number:		
Fax:			Fax:		
email:			email:		
effective date:			effective date:		
Authorizing Signature:			Date:		