OREGON BOARD OF OPTOMETRY

CHANGE OF ADDRESS NOTIFICATION

Licensee Name: _____ License Number: _____

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

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