



CHANGE OF ADDRESS NOTIFICATION

Persons holding a certificate or license to engage in the practice of podiatric medicine shall immediately notify the board of any changes of mailing address, giving both the old and new address.

LICENSE NUMBER:

NAME:

Last	First	Middle
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PREVIOUS ADDRESS:

Number/Street		
City	State	Zip Code

NEW BUSINESS ADDRESS:

Number/Street		Business Telephone (Including Area Code) ()
City	State	Zip Code

IF ADDRESS IS A P. O. BOX, YOU MUST PROVIDE A CONFIDENTIAL STREET ADDRESS:

Number/Street		
City	State	Zip Code

Please type or print clearly in ink.

Please check this box if you are requesting a replacement pocket license with the new business address.

This form must be mailed to the board at the address listed above with a \$40 processing fee.

If requesting a change of address only, you may fax your notification to the board at the fax number listed above.

I CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA TO THE TRUTH AND ACCURACY OF THE ABOVE INFORMATION.

Signature	Print Name	/ / Date
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