



ALASKA STATE MEDICAL BOARD

Department of Commerce, Community and Economic Development
Division of Corporations, Business and Professional Licensing
P. O. Box 110806
Juneau AK 99811-0806

CHANGE OF ADDRESS NOTIFICATION

Please print this form legibly and mail the original to the letterhead address.

NAME

(Last, First, Middle Initial/Name)

LICENSE NO.

 MD DO DPM PA-C MICP

Please change my address of record* to:

NEW ADDRESS

(City)

(State)

(Zip)

This is a:

Practice Address

Residence Address

TELEPHONE

(Day)

(Home)

EMAIL ADDRESS

Effective Date of this Address Change:

(MM/DD/YYYY)

SIGNATURE

(Must be signed by license holder only)

Date

*Address of Record is the official address to which all mail from the board will be sent. Please be aware that this is also considered public information.