Oregon

Theodore R. Kulongoski, Governor

Board of Medical Examiners
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ADDRESS CHANGE FORM

Licensee Name:______________________________ License Number:______________

Effective Date of this address change: ______________________

PHYSICAL PRACTICE LOCATION: ______________________________________
(Company Name) (If you don't have a practice address write the word 'NONE')

Street Address Only: ______________________________________
*** (PO Box Address below)**

City: ____________________ State: __________ Zip: __________

Telephone: ____________________ Oregon County: __________

Email Address: ____________________ Would you like your practice address posted on the Board's Website? ☐Yes ☐No

RESIDENCE ADDRESS: ______________________________________

City: ____________________ State: __________ Zip: __________

Telephone: ____________________ Oregon County: __________

Preferred Mailing Address: Practice Address ☐ Residence Address ☐

***MAILING ADDRESS:**
(If different from either above) ______________________________________
(Mailing address prints on Certificate of Registration)

Street or PO Box: ______________________________________

City: ____________________ State: __________ Zip: __________

Telephone: ____________________ Oregon County: __________

LOCATION OF FORMER OREGON PATIENTS' RECORDS:

Address: ______________________________________

Telephone: ____________________ Effective Date: __________

I would like a duplicate certificate of registration: ☐Yes ☐No

Send to my ☐ Practice ☐Residence ☐Other Address: ______________________________
Street City/State/Zip

Your certificate will be mailed to your indicated mailing address unless you specify otherwise.

Before