STATE OF CALIFORNIA
BOARD OF
PODIATRIC
MEDICINE

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

APPLICATION FOR CHANGE OF ADDRESS

FOR BPM USE ONLY			
Fee paid:		Receipt #:	
Date Cashiered:		Cashier's Initials:	
Date Approved:		Date Denial:	
Approved Initial:			

To request an address change for a Doctor of Podiatric Medicine permanent license or a Doctor of Podiatric Medicine Resident license, complete this form and return it to the mailing address below. If you requesting a replacement pocket license with the new address, please submit this form with a $40 check or money order made payable to: *Board of Podiatric Medicine.* **Please Note:** The public address of record will be disclosed to all persons or entities in response to a written or verbal request. The address of record will be posted on the Board of Podiatric Medicine's website once you have obtained a license.

Please print or type. Illegible application will be returned.

LICENSEE INFORMATION:

LICENSE NUMBER (IF KNOWN): _____ **E-MAIL:** _____

NAME:

PREVIOUS ADDRESS OF RECORD:

STREET ADDRESS

CITY STATE ZIP CODE COUNTRY

REQUEST TO HAVE MY ADDRESS OF RECORD CHANGED TO:

If the public address of record is a Post Office Box, a confidential street address must be provided. A confidential address will not be released to persons or entities.

STREET ADDRESS

CITY STATE ZIP CODE COUNTRY

CONFIDENTIAL STREET ADDRESS:

A confidential street address must be provided if the public address of record is a Post Office Box.

STREET ADDRESS

CITY STATE ZIP CODE COUNTRY

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

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

Signature Date

Signature and date are required to process this request.