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.