Oregon Medical Board
1500 SW First Ave Ste 620
Portland, OR 97201
Voice **(971) 673-2700**
FAX **(971) 673-2672**
www.oregon.gov/OMB

ADDRESS CHANGE FORM

Licensee Name: _____ **License Number:** _____

PREFERRED MAILING ADDRESS: ☐ PRACTICE; ☐ RESIDENCE; ☐ OTHER

PRACTICE & MAILING ADDRESSES ARE PUBLIC INFORMATION.

Do you want your practice address posted on the Board's Website? ☐ Yes; ☐ No

Effective Date of this address change: _____

PHYSICAL PRACTICE/TRAINING LOCATION (Business Name): _____

Practice address is **REQUIRED** to maintain an Active status. Your residence address will be used as your practice address if no practice address is designated.

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

City: _____ State: _____ Zip: _____

Telephone: _____ Oregon County: _____

Email Address: _____ Fax #: _____

RESIDENCE ADDRESS: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Cell Ph: _____

*** OTHER ADDRESS**
(If different from either address entered above): _____

Street **or** PO Box: _____

City: _____ State: _____ Zip: _____

Telephone: _____

LOCATION OF FORMER OREGON PATIENTS' RECORDS:

Address: _____

Telephone: _____ Effective Date: _____

Signature: _____ Date: _____

Change of Address information cannot be processed without your signature.

Please complete all information, and mail or fax to the Oregon Board.