



CHANGE OF ADDRESS REQUEST FORM

INSTRUCTIONS: Print in black ink or type. Fill out form completely and do not leave any questions blank.

Date: ____ / ____ / ____ License/Permit #: _____ (Required)

Name (Please print clearly): _____

Check one: I AM A ____ Dentist ____ Hygienist ____ OMS/Dental Assistant

I am requesting a change of address for my ____ HOME ____ OFFICE

• **Old Address:**

Street Address

City, State

Zip Code

• **New Address:**

Street Address

City, State

Zip Code

Effective ____ / ____ / _____, I am requesting the Oklahoma State Board of Dentistry to begin using the above address.

Signature

Daytime Phone Number