

**Board of Registration in Medicine**  
560 Harrison Avenue, Suite G-4, Boston, MA 02118  
[www.massmedboard.org](http://www.massmedboard.org) - Fax (617) 426-9358

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**CHANGE OF ADDRESS REQUEST**

**Instructions:** Type or print your name and address. You must list all addresses and indicate whether it is a "new" address or "no change." The Board will use your E-mail address to communicate directly with you. Please enter a fax number where you can receive confidential communications from the Board.

**Please note:** When you change your home or principal business address you are required to notify the Board within 30 days. The Board makes a licensee's business address available to the public and includes it in the physician Profile. If you do not have a business address, the Board will make public and use your mailing address, even if that mailing address is the same as your home address. The Board may also release a home address upon written request from a party upon a showing of good cause, for example, when an attorney seeks a home address for purposes of service of process. Thank you.

PHYSICIAN'S NAME: \_\_\_\_\_ License #: \_\_\_\_\_  
(print name)

**Mailing Address:** (check one)  **New address**  **No change**

Street Address: \_\_\_\_\_

Apartment # \_\_\_\_\_ Telephone #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Fax #: \_\_\_\_\_

**Home Address:** (check one)  **New address**  **No change**

Street Address: \_\_\_\_\_

Apartment # \_\_\_\_\_ Telephone #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_

**Business Address:** (check one)  **New address**  **No change**

Business Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_

Signature of Physician: \_\_\_\_\_ Date: \_\_\_\_\_

***Fax the completed form to the Board of Registration in Medicine at (617) 426-9358. If you need a new wallet card with your new mailing address, please attach your current wallet card to this form and mail to the Board of Registration in Medicine at the above listed address.***