

**Board of Registration in Medicine**  
**200 Harvard Mill Square, Suite 330, Wakefield, MA 01880**  
**Telephone: (781) 876-8210 - Fax (781) 876-8383**

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**CHANGE OF ADDRESS REQUEST FOR LIMITED LICENSEE**

**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.

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

<b><u>Mailing Address:</u></b>	<i>(check one)</i> <input type="checkbox"/> <b>New address</b>	<input type="checkbox"/> <b>No change</b>
Street Address: _____		
Apartment # _____ Telephone #: _____		
City: _____ State: _____ Zip: _____ Country: _____		
E-mail Address: _____ Fax #: _____		

<b><u>Home Address:</u></b>	<i>(check one)</i> <input type="checkbox"/> <b>New address</b>	<input type="checkbox"/> <b>No change</b>
Street Address: _____		
Apartment # _____ Telephone #: _____		
City: _____ State: _____ Zip: _____ Country: _____		

<b><u>Business Address:</u></b>	<i>(check one)</i> <input type="checkbox"/> <b>New address</b>	<input type="checkbox"/> <b>No change</b>
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 (781) 876-8383 or mail it to the Board of Registration in Medicine at the above listed address. Thank you.***