

Please mail or fax this form to:

Arizona Medical Board  
Arizona Regulatory Board of Physician Assistants  
Attention: Licensing Office  
9545 E. Doubletree Ranch Road  
Scottsdale, AZ 85258  
Fax: 480-551-2704



### ADDRESS CHANGE FORM

- You must notify the board in writing within 30 days of any change of office or home address and phone number
- Failure to do so may result in a monetary fine of \$100 plus the costs incurred by the Board to locate you
- Please print this form and provide all information on your address change as requested below. Please type or print legibly. Fax or mail the completed form to the Board
- In accordance with A.R.S. §32-3801, notwithstanding any law to the contrary, a professional's residential address and residential telephone number or numbers maintained by the professional board established pursuant to this title are not available to the public unless they are the only address and numbers of record.

Please record the following address changes: EFFECTIVE DATE: \_\_\_\_\_

PRACTICE: \_\_\_\_\_ (If you do not have a practice address or name write the word "NONE")  
(Company Name)

Street Address Only: \_\_\_\_\_  
(list P.O. Box as Mailing Address below)\*

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

Office Telephone: \_\_\_\_\_ Office Fax: \_\_\_\_\_

Office E-Mail: \_\_\_\_\_

RESIDENCE ADDRESS: \_\_\_\_\_

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

Telephone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Residence E-Mail: \_\_\_\_\_

**MAIL SHOULD BE SENT TO MY: Practice  Residence  The Address Below**

MAILING ADDRESS: \_\_\_\_\_  
(If different from either above)

Street or P.O. Box: \_\_\_\_\_

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

**\*\*If no practice address, do you want your home address listed on the website? Yes  No**

\_\_\_\_\_  
Name (Please print)

\_\_\_\_\_  
AZ License #

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Today's Date