



## APPLICATION FOR CHANGE OF ADDRESS

### FOR PMBC USE ONLY

Fee paid: _____	Receipt #: _____
Date Cashiered: _____	Cashier's Initials: _____
Date Approved: _____	Date Denied: _____
Approved Initial: _____	

If you need to update your address for your resident or permanent Doctor of Podiatric Medicine license, you may submit an application online in [BreEZe](#) or by completing this form and returning it to the mailing address below. If you're requesting a replacement pocket license with the new address, you may submit the request through your BreEZe account or by submitting this form with a \$100 check or money order made payable to: Podiatric Medical Board of California. **Please Note:** The address of record will not be posted on the Podiatric Medical Board of California's website.

*Please print or type. Illegible application will be returned.*

### LICENSEE INFORMATION:

LICENSE NUMBER (IF KNOWN): \_\_\_\_\_ \*E-MAIL: \_\_\_\_\_

NAME: \_\_\_\_\_

### PREVIOUS ADDRESS OF RECORD:

STREET ADDRESS  
\_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ COUNTRY \_\_\_\_\_

### REQUEST TO HAVE MY ADDRESS OF RECORD CHANGED TO:

STREET ADDRESS  
\_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ COUNTRY \_\_\_\_\_

### CONFIDENTIAL STREET ADDRESS:

STREET ADDRESS  
\_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ COUNTRY \_\_\_\_\_

Please check this box if you are requesting a replacement pocket license with the new business address.

**I CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA TO THE TRUTH AND ACCURACY OF THE ABOVE INFORMATION.**

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Signature and date are required to process this request.**

**\*By providing your e-mail address we can immediately send you valuable information and last-minute updates via e-mail or the Board's List Serv.**