



PHYSICIAN ASSISTANT BOARD
2005 Evergreen Street, Suite 1100, Sacramento, CA 95815
P (916) 561-8780 Fax(916) 263-2671 web www.pac.ca.gov

ADDRESS CHANGE FORM

This completed form should be mailed or faxed to the Physician Assistant Board.

The address you indicate as your address of record will be the address disclosed to all individuals making inquiries and will be utilized to mail all licenses, renewal notices, and other official correspondence.

NOTE: To request a replacement wallet receipt with your new address of record, you must complete and submit a Request for Duplicate form with a \$10.00 processing fee.

Name (Print or Type)	Telephone Number	License Number	Date of Birth
-------------------------	------------------	----------------	---------------

New Address of Record

Number	Street	City	State	Zip
--------	--------	------	-------	-----

Email:

NOTE: If a P.O. Box is listed, the law requires that you also provide a street address below under Confidential Address. This address will remain confidential.

Old Address of Record

Number	Street	City	State	Zip
--------	--------	------	-------	-----

Confidential Address (if required)

Number	Street	City	State	Zip
--------	--------	------	-------	-----

Note: Your confidential address will not be released to the public.

Signature

Date