STATE OF ARIZONA BOARD OF CHIROPRACTIC EXAMINERS
1951 West Camelback Road, Suite 330 · Phoenix, Arizona 85015
Telephone 602.864.5088 · Fax 602.864.5099
www.chiroboard.az.gov

Address Change Form

Please provide all information relating to your address change as requested below. Please print legibly.

1. Name:_____

   License Number:_____

   Change Effective Date:_____

2. **Primary Mailing Address.** This is the address where you receive your mail. It must be a post office box, personal mail box or office address. A home address will not be accepted unless it is your only address. Please note that this address will be a public record and will appear on the Board's website.

   Clinic Name:_____

   Street:_____

   City:_____ State:_____ Zip:_____

   Telephone: (_____) _____

3. **Practice Address and Phone Number.** This is the street address where you practice. If you have additional practice addresses, please attach a separate sheet.

   Clinic Name:_____

   Street:_____

   City:_____ State:_____ Zip:_____

   Telephone: (_____) _____

4. **Former Practice Address.** If you no longer practice at a location, please indicate so below. We will delete this address from your record. If you have additional deletions, please attach a separate sheet.

   Street:_____

   City:_____ State:_____ Zip:_____

   Telephone: (_____) _____

Over

5. If you are closing your practice, please indicate how patient records may be accessed below.

   - ❑ I am retaining my patient records and may be contacted regarding my records at the above mailing address.
   - ❑ I have transferred custody of my patient records to:

   Name:_____

   Street:_____

   City:_____State:_____Zip:_____

   Telephone: (_____)_____

6. **Home Address.** This is the physical address of your residence. While the law requires you to provide the Board with your home address, it also requires the Board to keep the address confidential, unless it is the only address on file. The following information shall be kept separate from public records in order to maintain confidentiality.

   Street:_____

   City:_____State:_____Zip:_____

   Telephone: (_____)_____

7. **Primary Contact Email**. The following information shall be kept separate from public records in order to maintain confidentiality.

   Email:_____

I, the undersigned, do hereby attest that I am the above-referenced licensee, and that the facts, statements, and answers given by me herein are true and correct.

Signature:_____**Date:**_____