MEDICAL BOARD OF CALIFORNIA
Licensing Program

FICTITIOUS NAME PERMIT
CHANGE OF ADDRESS FORM

PLEASE PRINT ALL INFORMATION CLEARLY.

FICTITIOUS NAME PERMIT #:

FICTITIOUS NAME:

PREVIOUS ADDRESS OF RECORD:

CITY	STATE	ZIP	COUNTRY

PLEASE CHANGE MY ADDRESS OF RECORD TO:
(Please allow only 30 characters per line for your address of record.)
Note: Pursuant to Business and Professions Code Section 2021(a)(b), your address of record is public information and will be posted on the Medical Board's Web site.

CITY	STATE	ZIP	COUNTRY

YOUR ADDRESS OF RECORD CANNOT BE A POST OFFICE BOX, A STREET ADDRESS MUST BE REPORTED.

PRACTICE TELEPHONE NUMBER: (PLEASE INCLUDE AREA CODE)

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT I AM A LICENSED PHYSICIAN OR PODIATRIST AND HAVE THE LEGAL AUTHORITY TO ACT ON BEHALF OF SAID FICTITIOUS NAME PERMIT HOLDER AND THAT THE INFORMATION CONTAINED ON THIS FORM IS TRUE AND CORRECT.

PRINT OR TYPE NAME	SIGNATURE	DATE	LICENSE #

FNP-005 (05/11)