Please fill out the change of address form below and mail or fax to:

Florida Department of Health
Division of Medical Quality Assurance
Board of Dentistry
4052 Bald Cypress Way
BIN #C-08
Tallahassee, Florida 32399-3290
FAX: 850-921-5389

ADDRESS CHANGE FORM

DENTAL

Please type or print in the appropriate spaces below if you have a change of address.

NAME:_____

EXAMINATION DATE:_____

CANDIDATE NUMBER:_____**FILE NUMBER**_____

PHONE NUMBERS: (H)_____ **(W)**_____
Area Code/Number **Area Code/Number**

OLDADDRESS:_____
_____
_____
_____

NEWADDRESS:_____
_____
_____
_____

SIGNATURE:_____

Note: If your name has changed, please use your prior name on this form and contact the Board Office for name change information.