

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

**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 HYGIENE

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

NAME: _____

EXAMINATION DATE: _____

CANDIDATE NUMBER: _____

PHONE NUMBERS: _____

Area Code/Number

Area Code/Number

OLD ADDRESS: _____

NEW ADDRESS: _____

SIGNATURE: _____

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

