



Nevada State Board of Dental Examiners
 6010 S. Rainbow Blvd., Bldg A, Ste. 1 • Las Vegas, NV 89118
 (702) 486-7044 • (800) DDS-EXAM • Fax (702) 486-7046

NOTICE OF ADDRESS CHANGE

Name of Licensee: _____ Effective Date: _____

Dental License Number: _____ Dental Hygiene License Number: _____

YOU MUST SPECIFY ALL CHANGES THAT ARE REQUIRED. You must designate which address you prefer for Board correspondence. If you do not designate an address, your primary office location will become your correspondence address. ATTACH ADDITIONAL PAGES IF MORE SPACE IS NEEDED IN REPORTING ALL LOCATIONS WHERE YOU PRACTICE.

NAC 631.150 Filing of addresses of licensee; notice of change; display of license. (NRS 631.190, 631.350)

1. Each licensee shall file with the Board the addresses of his permanent residence and the office or offices where he conducts his practice.
 2. Within 30 days after any change occurs in any of these addresses, the licensee shall give the Board a written notice of the change. **The Board will impose a fine of \$50 if a licensee does not report such a change within 30 days after it occurs.**
 3. The licensee shall display his license or a copy thereof at each place where he practices.
- [Bd. of Dental Exam'rs, § XVI, eff. 7-21-82]—(NAC A 9-6-96)

<input type="checkbox"/> New Home Address Street Address: _____ Apt No: _____ City: _____ State: _____ Zip Code: _____ Home Telephone: (_____) _____-_____ Cell Number: (_____) _____-_____ E-Mail Address: _____ <input type="checkbox"/> CORRESPONDENCE ADDRESS – PUBLIC RECORD	Practice Address: (Check One) <input type="checkbox"/> PRIMARY Office <input type="checkbox"/> ADDITIONAL Office <input type="checkbox"/> REMOVE Office - No longer practicing at office Office Name: _____ Street Address: _____ Suite No: _____ City: _____ State: _____ Zip Code: _____ Office Number: (_____) _____-_____ Fax Number: (_____) _____-_____ <input type="checkbox"/> CORRESPONDENCE ADDRESS – PUBLIC RECORD
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Practice Address: (Check One) <input type="checkbox"/> PRIMARY Office <input type="checkbox"/> ADDITIONAL Office <input type="checkbox"/> REMOVE Office - No longer practicing at office Office Name: _____ Street Address: _____ Suite No: _____ City: _____ State: _____ Zip Code: _____ Office Number: (_____) _____-_____ Fax Number: (_____) _____-_____ <input type="checkbox"/> CORRESPONDENCE ADDRESS – PUBLIC RECORD	Practice Address: (Check One) <input type="checkbox"/> PRIMARY Office <input type="checkbox"/> ADDITIONAL Office <input type="checkbox"/> REMOVE Office - No longer practicing at office Office Name: _____ Street Address: _____ Suite No: _____ City: _____ State: _____ Zip Code: _____ Office Number: (_____) _____-_____ Fax Number: (_____) _____-_____ <input type="checkbox"/> CORRESPONDENCE ADDRESS – PUBLIC RECORD
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Licensee Signature: _____ Date: _____