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)

[ ] New Home Address

Street Address: ____

Apt No: ____________ **City:** ____________________

State: __________________ **Zip Code:** ________________

Home Telephone: (______) _________-__________

Cell Number: (______) _________-__________

E-Mail Address: ____

[ ] CORRESPONDENCE ADDRESS – PUBLIC RECORD

Practice Address: (Check One)
[ ] PRIMARY Office
[ ] ADDITIONAL Office
[ ] REMOVE Office - No longer practicing at office

Office Name: ____

Street Address: ____

Suite No: ____________ **City:** ____________________

State: __________________ **Zip Code:** ________________

Office Number: (______) _________-__________

Fax Number: (______) _________-__________

[ ] CORRESPONDENCE ADDRESS – PUBLIC RECORD

Practice Address: (Check One)
[ ] PRIMARY Office
[ ] ADDITIONAL Office
[ ] REMOVE Office - No longer practicing at office

Office Name: ____

Street Address: ____

Suite No: ____________ **City:** ____________________

State: __________________ **Zip Code:** ________________

Office Number: (______) _________-__________

Fax Number: (______) _________-__________

[ ] CORRESPONDENCE ADDRESS – PUBLIC RECORD

Practice Address: (Check One)
[ ] PRIMARY Office
[ ] ADDITIONAL Office
[ ] REMOVE Office - No longer practicing at office

Office Name: ____

Street Address: ____

Suite No: ____________ **City:** ____________________

State: __________________ **Zip Code:** ________________

Office Number: (______) _________-__________

Fax Number: (______) _________-__________

[ ] CORRESPONDENCE ADDRESS – PUBLIC RECORD

Licensee Signature: _____ **Date:** _____