Nevada State Board of Dental Examiners
2651 N. Green Valley Parkway, Suite 104, Henderson, NV 89014
(702) 486-7044 • (800) DDS-EXAM • Fax (702) 486-7046
nsbde@dental.nv.gov

NOTICE OF ADDRESS CHANGE

Name of Licensee: _____ **Effective Date:** _____

Dental License Number: _____ **Do you hold a Sedation or Site Permit:** ☐ **YES** ☐ **NO**

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 or her permanent residence and the office or offices where he or she conducts his or her practice, including, without limitation, any electronic mail address for that 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 or her license and any permit issued by the Board, or a copy thereof, at each place where he or she practices.

[Bd. of Dental Exam'rs, § XVI, eff. 7-21-82] — (NAC A 9-6-96; R066-11, 2-15-2012; R119-15, 6-28-2016)

☐ **New Home Address**	**Practice Address** (Check One): ☐ **PRIMARY Office** ☐ **REMOVE Office** – No longer practicing at office
Street Address: _____ Apt. No.: _____ City: _____ State: _____ Zip Code: _____ Home Telephone: (_____) _____ - _____ Cell Number: (_____) _____ - _____ E-Mail Address: _____ ☐ **CORRESPONDENCE ADDRESS – PUBLIC RECORD**	Office Name: _____ Street Address: _____ Suite. No.: _____ City: _____ State: _____ Zip Code: _____ Office Number: (_____) _____ - _____ Fax Number: (_____) _____ - _____ ☐ **CORRESPONDENCE ADDRESS – PUBLIC RECORD**

Practice Address (Check One): ☐ **ADDITIONAL Office** ☐ **REMOVE Office** – No longer practicing at office	**Practice Address** (Check One): ☐ **ADDITIONAL Office** ☐ **REMOVE Office** – No longer practicing at office
Office Name: _____ Street Address: _____ Suite. No.: _____ City: _____ State: _____ Zip Code: _____ Office Number: (_____) _____ - _____ Fax Number: (_____) _____ - _____	Office Name: _____ Street Address: _____ Suite. No.: _____ City: _____ State: _____ Zip Code: _____ Office Number: (_____) _____ - _____ Fax Number: (_____) _____ - _____

Licensee Signature: _____ **Date:** _____