



Douglas A. Ducey
Governor

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Sarah Penttinen
Executive Director

CHANGE OF ADDRESS

PLEASE SELECT ONE: _____ Office change of address _____ Home change of address

FULL NAME: _____

License #: _____

OLD address: _____
Street address and unit number

City, state and zip code

(_____) _____ (_____) _____
Phone Fax

NEW address: _____
Street address and unit number

City, state and zip code

(_____) _____ (_____) _____
Phone Fax

EFFECTIVE DATE OF CHANGE: _____
(Remember: You must notify the Board of your change of address within 30 days of the change.)

Signature of physician
(Must be signed by the physician only)

Date

Please fax this form to the fax number listed above or send via regular mail to the Board's office.