



# MARYLAND STATE BOARD OF CHIROPRACTIC EXAMINERS

4201 Patterson Avenue, Suite 301

Baltimore, MD 21215

410-764-4738

Website: [www.health.maryland.gov/chiropactic](http://www.health.maryland.gov/chiropactic); Email: [mdh.chiropractic@maryland.gov](mailto:mdh.chiropractic@maryland.gov)

## OFFICIAL NOTIFICATION OF ADDRESS CHANGE

*Please type or print all information. Pursuant to COMAR 10.43.01.05F, written notification of name and/or address changes must be made to the Board within 60 days of the applicable change. A \$200.00 penalty is assessed for failure to comply. Make check payable to the MD State Board of Chiropractic Examiners.*

**Submit proof of address change with this form. Example: copy of State Driver's License or State Identification Card.**

Licensing Status with the Board (Check one):

Licensee

Registrant

Applicant

**CURRENT ADDRESS ON FILE  
WITH THE BOARD**

Name: \_\_\_\_\_ License/Registration Number: \_\_\_\_\_

Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Indicate type of address (check one):

Home

Business

Other

**NEW ADDRESS**

Residence: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Business Name and Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

I attest that the above statements are true to the best of my knowledge and beliefs. I understand that any false or misleading information in this notification may be cause for denial or loss of licensure/registration and may result in administrative prosecution.

Signature \_\_\_\_\_

Date \_\_\_\_\_

### **BOARD USE ONLY**

Check Date: \_\_\_\_\_ Check #: \_\_\_\_\_ Check Amount: \$ \_\_\_\_\_ Initials: \_\_\_\_\_