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Arkansas State Board of Dental Examiners

CHANGE OF ADDRESS FORM

NAME: _____ LICENSE #: _____

I AM A: ☐ Dentist ☐ Registered Dental Hygienist ☐ Registered Dental Assistant

I WOULD LIKE TO NOTIFY THE BOARD OF THE CHANGE OF MY:

☐ Name — Former Name: _____ New name: _____

☐ Home address — Old Address: _____ New Address: _____

☐ Office Address — Old Address: _____ New Address: _____

☐ Phone & Fax Numbers — Old phone & fax #'s: _____ New phone & fax #'s: _____

For newly licensed dentists in Arkansas only:

☐ I would like to receive the Education Packet for registering dental assistants in Arkansas.

INSTRUCTIONS:
You can print this form by clicking on the "Print Form" button and submit it to the Board office by mail (101 E. Capitol Avenue, Suite 111, Little Rock AR 72201) or by fax (501-682-3543). You can also submit this form via email by clicking on the "Submit by Email" button.