CHANGE OF ADDRESS REQUEST

Please enter required information, sign and date at the bottom of the page.
Mail, fax, or e-mail form.

Name: _____ License Number: ____ - _____

Effective Date of Change: _____ / _____/ _____

PLEASE CHANGE THE CURRENT ☐ MAILING ADDRESS

TO _____
Street

_____ _____ _____
City State Zip

Telephone Number: _____ - _____ - _____

E-mail Address: _____

PLEASE CHANGE THE CURRENT ☐ PRACTICE ADDRESS

TO _____
Street

_____ _____ _____
City State Zip

Telephone Number: _____ - _____ - _____

E-mail Address: _____

The licensee shall notify the board in writing of any change of address within 30 days after the date of such change. (K.S.A 74-7025)

I certify under penalty of perjury under the laws of the State of Kansas that the information provided on this form is true and correct and that I am licensed to practice in the State of Kansas.

_____
Signature Date

Kansas State Board of Technical Professions
900 SW Jackson, Ste 507 Topeka KS 66612-1257
Voice: 785-296-3053 Fax: 785-296-0167 E-mail: ksbtpadmin@ks.gov

Revised 9-21-16 se