Texas State Board of Podiatric Medical Examiners

MAILING ADDRESS: P.O. Box 12216, Austin, TX 78711-2216 **PHYSICAL ADDRESS**: 333 Guadalupe, Suite #2-320, Austin, TX 78701
TELEPHONE: 512.305.7000 **FAX:** 512.305.7003 **WEBSITE ADDRESS:** www.foot.state.tx.us

TSBPME CHANGE OF ADDRESS REQUEST FORM

Agency Use Only: Processed By: _____; Date Database Updated: _____

Instructions:
1) Print in black/blue ink or type.
2) Fill out form completely and do not leave any questions blank. If an item is not applicable, mark "N/A."
3) This form MUST be signed by the Podiatric Physician / License Holder.
4) Upon completion, Print and Fax to (512)-305-7003 or submit to the Mailing Address above.

Podiatric Physician Name: _____

Texas License Number: _____

Please indicate (√ one box only) which address (listed below) is your new PREFERRED Mailing Address: Office ☐ Home ☐
(Note: "Preferred" address is available to the public.)

► **OFFICE ADDRESS CHANGE**

- **Current Address:** _____

  _____

  _____

  Phone: (___) _____ **Fax:** (___) _____ **E-Mail:** _____

- **New Address:** _____

  _____

  _____

  Phone: (___) _____ **Fax:** (___) _____ **E-Mail:** _____

► **HOME ADDRESS CHANGE**

- **Current Address:** _____

  _____

  _____

  Phone: (___) _____ **Fax:** (___) _____ **E-Mail:** _____

- **New Address:** _____

  _____

  _____

  Phone: (___) _____ **Fax:** (___) _____ **E-Mail:** _____

► **RADIOLOGY TECHNICIANS**

Does this address change need to be made (√ one box only) for any Radiology Technicians affiliated with your office/practice?

Yes ☐ **No** ☐

If "Yes," please list all Radiology Technicians:

1. **Name:** _____ **Registration #:** _____
2. **Name:** _____ **Registration #:** _____
3. **Name:** _____ **Registration #:** _____
4. **Name:** _____ **Registration #:** _____
5. **Name:** _____ **Registration #:** _____
6. **Name:** _____ **Registration #:** _____
7. **Name:** _____ **Registration #:** _____
8. **Name:** _____ **Registration #:** _____
9. **Name:** _____ **Registration #:** _____
10. **Name:** _____ **Registration #:** _____

► **ADDITIONAL COMMENTS**

_____

_____

_____

_____

_____

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY AND INDICATE YOUR UNDERSTANDING AND ACCEPTANCE BY SIGNING IN THE SPACE PROVIDED.

1. I certify that all the information provided by me in connection with this form is true and complete.
2. I am the person named/identified in this form.
3. I understand it is a criminal violation (Texas Penal Code §37.10) to submit false information to a governmental agency.

► ***THIS FORM MUST BE SIGNED AND DATED:***

_____ _____

PODIATRIC PHYSICIAN (LICENSE HOLDER) SIGNATURE **DATE**