

**STATE OF NEW HAMPSHIRE**

**OPHTHALMIC DISPENSERS**

121 South Fruit Street  
Concord, NH 03301  
Phone - (603) 271-6762 Fax - (603) 271-6702

**CHANGE OF ADDRESS FORM**

(Please assure that this form is printed and legible)

Last name: \_\_\_\_\_ First name: \_\_\_\_\_

Profession: \_\_\_\_\_ License # \_\_\_\_\_

**Your mailing address is available to the public.**

**New Mailing Address:** Please circle one: Home Business

Business name and/or employer's name \_\_\_\_\_  
(if applicable)

Address: \_\_\_\_\_ Ste.# \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Current Business phone number \_\_\_\_\_

Current Home phone number \_\_\_\_\_

If the mailing address listed above is a business address please provide the Board with a current home address for its confidential records.

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email address: \_\_\_\_\_ (for Board use only)

This form **MUST** be signed and dated in order for these changes to be completed.

Licensee's signature: \_\_\_\_\_ Date: \_\_\_\_\_

This form may be mailed to the address listed above or faxed to (603) 271-6702

01/09/2018