

**ARIZONA NATUROPATHIC PHYSICIANS MEDICAL BOARD  
ADDRESS CHANGE FORM – DUPLICATE REQUEST FORM**

**32-1507. Change in status; assessment of costs** Each person who holds a license or certificate pursuant to this chapter shall inform the board in writing, within thirty days, of any change in status of that person's initial application including any change of name, residence, practice address and telephone number and of each subsequent change of status. A licensee's or a certificate holder's residential address and residential telephone number or numbers are not available to the public unless they are the only address and numbers of record. The board may assess the costs incurred by the board in locating a person who is licensed or certified pursuant to this chapter to that person.

**32-1508. Display of licenses and certificates** A person who holds a license or certificate pursuant to this chapter shall display that document in a conspicuous place that is accessible to view by the public. A person who practices, conducts affairs or is employed at more than one location and who maintains a continuing activity as authorized by the license or certificate shall display a duplicate of that document issued by the board at each location.

NAME \_\_\_\_\_ SS# \_\_\_\_\_

License No. \_\_\_\_\_ Certificate No. \_\_\_\_\_

**I AM REQUESTING A DUPLICATE**

**MEDICAL LICNESE**  **Fee of \$20.00**

**CERTIFICATE TO DISPENSE**  **Fee of \$20.00**

**NO DUPLICATE(s) NEEDED**

**FOR THE FOLLOWING ADDRESS:**

Address \_\_\_\_\_  
Ste # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ FAX \_\_\_\_\_ EMAIL \_\_\_\_\_

Practice Name if applicable \_\_\_\_\_

**This is my: Primary Location** \_\_\_\_\_ **Additional Location** \_\_\_\_\_ **Residence** \_\_\_\_\_ **Use as mailing address** \_\_\_\_\_

**Please remove my affiliation with the following location:**

Address \_\_\_\_\_  
Ste # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ FAX \_\_\_\_\_

Practice Name if applicable: \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Please mail your this form along with the appropriate fee to: AZ. Naturopathic Physicians Medical Board  
1400 W. Washington, Ste. 300, Phoenix, AZ 85007**

Personal check or money order is an acceptable form of payment. Credit Cards are not accepted. A \$25.00 fee will result in NSF returned checks.  
**Fees are non-refundable.** Incomplete, forms submitted with out payment or **unreadable** forms will not be processed.