DEPARTMENT OF HEALTH
OFFICE OF PROFESSIONAL LICENSURE AND HEALTH PLANNING
P.O. BOX 222995, CHRISTIANSTED, VI 00822-2995

CHANGE OF ADDRESS FORM

USER FILLABLE FORM

NAME: _____

(PRINT) LAST FIRST MI

LAST 4 DIGITS OF SSN: ____ ____ ____ ____

LICENSE #: _____ TELEPHONE #: _____

EMAIL ADDRESS: _____

OLD MAILING ADDRESS:

_____

_____

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_____

NEW MAILING ADDRESS:

_____

_____

_____

_____

SIGNATURE: _____ DATE: _____

*Email to any PLHP staff: deborah.richardson-peter@doh.vi.gov; jahkesha.archibald@doh.vi.gov; ramona.liger@doh.vi.gov; or renise.james@doh.vi.gov