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:

NEW MAILING ADDRESS:

SIGNATURE: _____ DATE: _____

***EMAIL TO:** PLHPDOCUMENTS@DOH.VI.GOV