



**Uniform Stamp: Change of Address**

Name (last) (first) (middle initial)			CA Medical License Number (Physicians Only)		
Former Address		City	County	State	ZIP code
Current Address		City	County	State	ZIP code
Day Time Phone Number		Other Phone Number		Fax	
Email Address			Effective Date of Change		
Signature of Applicant			Date		

**Change of Facility Name**

Former Facility Name	Current Facility Name
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**OFFICE USE ONLY**

Date Received	<b>Return To:</b> <b>Yellow Fever Vaccine Program</b> California Department of Public Health Immunization Branch 850 Marina Bay Pkwy., Bldg. P Richmond, CA 94804
Updated	
Notified	