CHANGE OF INFORMATION

Date Change Effective: ______/______/______

☐ DVM ☐ RVT

NAME: ____________________________________ License/Registration #:______________

☐ **NAME CHANGE**

FROM: ____

TO: ____

REASON FOR CHANGE: ____

☐ **BUSINESS ADDRESS CHANGE**

TO: ____
Name of Clinic or Facility

____
Street Address

____
City State Zip County

____
Telephone # Fax #

☐ **RESIDENCE ADDRESS CHANGE:**

TO: ____
Street Address

____
City State Zip County

____
Telephone # Cell #

○ ***Indicate here if you prefer all correspondence be mailed to your business instead of residence address.***

Changes will be accepted by mail, fax or email:

RETURN FORM TO:

The Ohio Veterinary Medical Licensing Board
77 South High Street, 16th Floor
Columbus, Ohio 43215-6108

Fax: 614-644-9038 Email: info@ovmlb.state.oh.us