



LOUISIANA STATE BOARD OF DENTISTRY
365 CANAL STREET, SUITE 2680
NEW ORLEANS, LOUISIANA 70130
TELEPHONE (504) 568-8574 • FAX (504) 568-8598

CHANGE OF INFORMATION FORM

§304. Address of Dental Practice

A. Each dentist shall inform the Louisiana State Board of Dentistry of his official mailing address and all office addresses at which the dentist practices dentistry within 30 days of changing his official mailing address or commencing practice at each location.

B. Failure of a dentist to notify the board within 30 days of any change of official mailing address or office move or relocation will result in the imposition of any one or more of the penalties set forth in R.S. 37:780(B).

C. Within 30 days following the abandonment of any office located within Louisiana, all signs or references to the practice of dentistry at said former office by the dentist shall be removed. This pertains to all references whether attached or not attached to the abandoned premises. A licensee's failure to remove said signs in accordance with this Section will result in the imposition of any one or more of the penalties set forth in R.S. 37:780(B).

§703. Address of Employment and Mailing Address

A. Each dental hygienist shall inform the Louisiana State Board of Dentistry of his or her official mailing address and all office addresses at which the dental hygienist is employed as a dental hygienist and the name of the employing dentist. Failure of a dental hygienist to notify the board within 30 days of a change in the mailing address or address of employment as a dental hygienist and the name of the new employing dentist will result in the imposition of any one or more of the penalties set forth in R.S. 37:780(B).

If you have a change of address, you may report same to the Louisiana State Board of Dentistry by using this form. You may mail this form to the Board office address listed above or send it via facsimile to (504)568-8598.

Full Name: _____

LA License No. _____ Dentist Hygienist

Old Address: _____

New Address: _____

Telephone: _____ Effective Date of Change: _____

Employer: _____

Type of Change: Home Address Mailing Address Office Address Employer Additional office

Please remove the following office(s) from my record: _____

If you currently hold an office permit for the administration of anesthesia/analgesia at an office address you are deleting and plan to administer same at you new office location, you must submit an office anesthesia/analgesia permit. Office permits do not transfer.

 Signature of Licensee

 Date