



MEDICAL BOARD OF CALIFORNIA Licensing Program



Fictitious Name Permit Notification of Partnership Change

Fictitious Name: _____

FNP #: _____

Current Physical Practice Address:
(No PO Box)

Phone #: _____

Business Type: **PARTNERSHIP**

If you wish to *add or delete partners*, please provide the following information in the table below. Signatures are required to associate or disassociate partners, and this form also must include a signature at the bottom signed by a current partner.

<u>Doctor's Name (print or type)</u>	<u>License #</u>	<u>Association Date</u>	<u>Disassociation Date</u>	<u>Signature</u>

I certify, under penalty of perjury, and the laws of the State of California, that the information provided in this "Notification of Partnership Change" form, including any supporting documents, are true and correct. I further certify that I am a partner authorized to act on behalf of the above-stated entity, and the information contained herein is true and correct.

Print or Type Name

Partner's Signature

Date

License #