



MEDICAL BOARD OF CALIFORNIA

Protecting consumers by advancing high quality, safe medical care.

Licensing Program
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Gavin Newsom, Governor, State of California | Business, Consumer Services and Housing Agency | Department of Consumer Affairs

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 #