

**UWHC House Officer Forwarding Address Form
2008**

Name: _____

Department: _____

Home Address:

Street Address: _____

City, State, Zip: _____

Telephone Number: _____

Email Address: _____

Work Address:

Institution: _____

Street Address: _____

City, State, Zip: _____

Telephone Number: _____

Type of Affiliation:

- Further Clinical Training. Specialty _____
- Private Practice
- Academic Practice
- Research
- Other _____

Effective Date: _____

To: Wisconsin Medical Examining Board
Department of Regulation and Licensing
P.O. Box 8935
Madison, WI 53708-8935

From: _____

Re: Address Change

Can be completed on line at:

<https://www.deadiversion.usdoj.gov/webforms/jsp/regapps/common/updateLogin.jsp>

Or this letter can be submitted.

This is to inform you of my change of address. All correspondence regarding my medical license should be sent to me at the following address, effective the date listed below.

Name: _____

License number: _____

New Mailing Address: _____

Effective Date: _____

Signature: _____

To: Wisconsin Patients Compensation Fund
P.O. Box 7873
Madison WI 53707-7873

From: _____

Re: Address Change

This is to inform you of my change of address. All correspondence regarding my participation in the fund should be sent to me at the following address, effective the date listed below.

Name: _____

Medical License number: _____

New Mailing Address: _____

Effective Date: _____

Signature: _____