CHANGE OF PRACTICE ADDRESS
FOR APRN WITH A (CAPA –CS)

This form is to be used ONLY to notify KBN of an address change of the primary practice site. DO NOT use this form if there are any other changes to or a rescission of the CAPA-CS.

APRN Last Name

Physician's Last Name

APRN First Name

Physician's First Name

APRN Registration Number

Physician's License Number

PREVIOUS PRACTICE ADDRESS:

Practice Name

Address

City State Zip Code

NEW ADDRESS OF PRACTICE SITE:

Address

City State Zip Code

- -

Area Code Phone number

I acknowledge that the information contained herein is true and accurate.

APRN signature Date signed

Upon completion of this form, please return to:

Kentucky Board of Nursing
312 Whittington Parkway
Suite 300
Attn: APRN Program Coordinator
Louisville, KY 40222

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