NORTH CAROLINA BOARD
of LICENSED CLINICAL
MENTAL HEALTH
COUNSELORS

PHONE: 844-622-3572
FAX: 336-217-9450
WEB: ncblcmhc.org
EMAIL: LCMHCinfo@ncblcmhc.org

Change of Address Form

Changes must be mailed.

Mail this form to: NCBLCMHC
PO Box 77819
Greensboro NC 27417

Faxes are not accepted

Please print your first, middle and last name, along with your license number (if applicable), to help in finding your records in our database.

First Name	Middle Name	Last Name
____________________	____________________	____________________

NCBLCMHC License#________________ **OR** SS # _______ - _______ - _______

Old Address ____

HOME ADDRESS

Street 1) ____

Street 2) ____

City ____________________ State ____________ ZIP ________

Phone (________) ____________________ Fax (_________) ____________________

Email ____

WORK ADDRESS

Street 1) ____

Street 2) ____

City ____________________ State ____________ ZIP ________

Phone (________) ____________________ Fax (_________) ____________________

Email ____

This form must be signed by the licensee/applicant in order to be processed.

______________________________ ______________

Signature Date

There is no charge for changing your address with the Board. The Board requires all licensees and applicants maintain a current address on file with the Board office. Changes of address should be submitted within 60 days of move.