



**Mississippi**  
**State Board of Examiners for**  
**Social Workers and Marriage & Family Therapists**  
**Post Office Box 4508**  
**Jackson, MS 39296-4508**  
**601-987-6806/Fax: 601-987-6808**  
**www.swmft.ms.gov**

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## **ADDRESS CHANGE FORM**

License Number: \_\_\_\_\_ Last four digits of SSN: XXX-XX- \_\_\_\_\_

Name: \_\_\_\_\_  
First MI Last

Previous Address: \_\_\_\_\_  
\_\_\_\_\_

New Address: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
County of Residence Telephone Number

I, the undersigned, do hereby solemnly swear or affirm that I am the above licensee, and that the statements contained therein or accompanying this form are true to the best of my knowledge and belief.

\_\_\_\_\_  
Licensee's Signature Date

Mail to: MBOE, P.O. Box 4508, Jackson, MS 39296-4508 OR  
Email to: [info@swmft.ms.gov](mailto:info@swmft.ms.gov)