



MEMBERSHIP CHANGE FORM
 718 E. Manchester Blvd., Ste. F,G,H
 Inglewood, CA 90301

Phone: 310-671-3650
 Fax: 310-672-3650
 E-mail: info@inglewoodbor.com
www.inglewoodbor.org
 Revised Date: 7/11/14

Office use only: ___ IBOR ___ MLS ___ Both ___ AFF
Member Type: ___ APP ___ AST ___ DR ___ DRS ___ R ___ RS ___ MB ___ MBS ___ MU

Personal E-mail Change	Personal Address / Phone # Change	Personal Name Change
Firm Name Change	Firm Address / Phone # Change	Transfer to another Firm

Date: ___ / ___ / ___	NRDS ID: _____ ----- Member #:	CRMLS Public ID: _____ ----- DRE License #:
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PLEASE PRINT

*****PERSONAL INFORMATION IS REQUIRED*****

Last Name: _____ First Name: _____ M.I: _____
 Home Address: _____ City: _____ Zip: _____
 Home Phone #: _____ Agent Fax #: _____
 Direct Office Phone #: _____ Office Extension: _____
 Cell Phone #: _____ E-Mail: _____

PREVIOUS OFFICE INFORMATION:

For office use only Office #: **N** _____

Office Name: _____ Broker Name: _____
 Address: _____ Phone #: _____

NEW OFFICE INFORMATION: **For office use only** Office ID: _____ NRDS ID: _____

Office Name: _____
 Broker Name: _____ **For office use only** NRDS ID: _____
 Address: _____ City: _____ Zip: _____
 Office Phone #: _____ Office Fax #: _____

*****REQUIRED: ALL MLS SUBSCRIBERS/PARTICIPANTS: (Please circle one)*****

Do you want your ACTIVE LISTINGS to show under old office or new office? **N/A or OLD or NEW**

Do you have a Supra Key? **YES or NO** **For office use only** Keyholder I.D. _____

I Have ___ I Have not ___ a written contract of employment and notified the Department of Real Estate.
(Please check one)

PREFERRED MAILING ADDRESS (Please check one) *All invoices and billing information will be sent via email*	<u>Home</u>	<u>Office</u>
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Member's Signature: X _____

New Broker's Signature: X _____

A Listing Release signed by your previous broker is Required if a new office needs to be reflected on Active listings

<u>For office use only</u>	
___ Check ALL listings & get DR release.	
___ Magic	___ zipForm 6
___ MLS/Yes	___ NRDS
___ Supra	___ Initials
___ Billing Type	___ Date
OFFICE NAME: _____	