Virginia Department of
Health Professions
Board of Medicine

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NAME/ADDRESS CHANGE FORM

This form may be faxed, emailed or mailed to the board office. **Please allow 7-10 business days for processing.**

CURRENT INFORMATION ON LICENSE OR REGISTRATION:

Last Name	**First Name**	**M.I.**	**Maiden or Other**

License or Registration Number	**Last four digits of your Social Security Number** XXX-XX-
Contact number	**Email address**

☐ **CHANGE OF NAME**

****You must submit a copy of a legal document verifying your new name. The following are acceptable name change verification documents**:

(1) Marriage certificate;
(2) Divorce decree which indicates the retaking of your maiden name;
(3) Other legal document indicating the retaking of your maiden name;
(4) Copy of court documents

NEW NAME:

Last	First	M. I.

☐ **CHANGE OF ADDRESS**

Previous Street Address		
City	State	Zip

NEW PUBLIC ADDRESS:

Street Address		
City	State	Zip

NEW PRIVATE ADDRESS:

Street Address		
City	State	Zip

Please note: If no public address is provided, your private address becomes public.

THE FOLLOWING FEES DO NOT APPLY TO: REGISTERED SURGICAL TECHNOLOGISTS OR SURGICAL ASSISTANTS

☐ **Attached is my check/money order for $5.00 payable to the "Treasurer of Virginia" for a copy of my updated license.**
☐ **Attached is my check/money order for $15.00 payable to the "Treasurer of Virginia" for a replacement wall certificate.**

Current e-mail address: _____

SIGNATURE OF LICENSEE _____ **DATE** _____