**Commonwealth of Massachusetts Board of Registration in Medicine**

**178 Albion Street, Suite 330 – Wakefield, MA 01880**

**Telephone: (781) 876-8210 Fax: (781) 876-8383**

[**www.mass.gov/massmedboard**](http://www.mass.gov/massmedboard)

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| **NAME CHANGE AND DUPLICATE LICENSE REQUEST** |
| **INSTRUCTIONS:** Complete the following information and submit copies of the required documentation to support your name change request. Return form to the attention of the Licensing Division at the above address. |

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| **NAME CHANGE INFORMATION** |
| **Former Name** | **Last First Middle**  |
| **New Name**  | **Last First Middle**  |
| **Mailing Address**  | **Number and Street** |
| **City State/Province/Territory Zip (or postal) Code** |
| **MA License #** |  | **Date of Birth** | \_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_ Month Day Year |

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| **REQUIRED DOCUMENTATION** |
| **You must submit photocopies of the following two required documents:** 1. A current government issued photographic identification (e.g., driver license, passport, etc.); AND
2. One of the following additional legal documents as proof of name change:

[ ]  Certified Court Order [ ]  Marriage Certificate [ ]  Divorce Decree**If you currently hold a full license in Massachusetts, you must also submit the following:** [ ]  Original wall certificate; AND[ ]  Wallet sized license card. |

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| **ATTESTATION** |
| Under the penalties of perjury, I declare that to the best of my knowledge and belief, the information contained herein and evidence submitted herewith are true, correct and complete. I understand that any falsification or misrepresentation of any item on this form or any attachment hereto may be a sufficient basis for denying or revoking a license. **SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |