Commonwealth of Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 – Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383
www.mass.gov/massmedboard

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.

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

REQUIRED DOCUMENTATION

You must submit photocopies of the following <u>two</u> required documents:

1. A current government issued photographic identification (e.g., driver license, passport, etc.); <u>AND</u>
2. One of the following additional legal documents as proof of name change:
   - ☐ Certified Court Order
   - ☐ Marriage Certificate
   - ☐ Divorce Decree

If you <u>currently</u> hold a full license in Massachusetts, you must also submit the following:

- ☐ Original wall certificate; <u>AND</u>
- ☐ Wallet sized license card.

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:** _____