MAILING ADDRESS:	STATE BOARD OF MEDICINE	COURIER ADDRESS:
PO BOX 2649 Harrisburg, PA 17105-2649	Email: st-medicine@pa.gov Phone: (717) 783-1400 or (717) 787-2381 Fax: (717) 787-7769 Website: www.dos.pa.gov/med	2601 North Third Street Harrisburg, PA 17110

REQUEST FOR CHANGE OF NAME – ADDRESS AND/OR EMAIL

- **FEE: To obtain a duplicate license reflecting the change of name and/or address, you must return this application and a $5 fee (check or money order payable to the "Commonwealth of Pennsylvania."**
- **Without the $5 fee, the change will be processed but no duplicate will be issued.**
- **A processing fee of $20 will be charged for any check/money order returned unpaid by your bank regardless of the reason for non-payment.**

LICENSEE INFORMATION

PLEASE PRINT OR TYPE

LICENSEE'S NAME:	Last			First		Middle
LICENSE #:		**TELEPHONE NUMBER:**			**DATE OF BIRTH:**	
SSN:				**EMAIL ADDRESS:**		

☐ **CHANGE OF NAME**

You must submit a copy of a legal document verifying the name as it is currently listed in the Board's records and also provide the 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 a maiden name;
(4) For a "legal" name change, a copy of the court document must be provided

NEW NAME:	Last	First	Middle

☐ **CHANGE OF ADDRESS**

OLD ADDRESS:			
	City	State	Zip Code
NEW ADDRESS:			
	City	State	Zip Code

☐ **CHANGE OF EMAIL**

OLD EMAIL ADDRESS:	
NEW EMAIL ADDRESS:	