Name Change & Duplication Request Form

STATE MAIL IS NOT FORWARDED TO ANY OTHER ADDRESS AND IT IS RETURNED TO THIS OFFICE.

RSA 328-F: 21 Administrative Obligations of Licensees. I. Licensees shall maintain their current business and home addresses on file with their governing boards. Any changes in address shall be provided to the office **no later than 30 days** from the date of the change. II. Licensees shall notify their governing boards if licenses or other proof of licensure are lost or stolen.

General Information: Please print legibly - This section required for all requests

Name: _____ Social Security #: _____

Profession: _____ License #: _____

Home Mailing Address: (City, State, and Zip Code Required)

_____

_____

For name change, please include duplication of legal documentation. (Marriage License, Divorce Decree, or other legal papers)

Name Change: (First, Middle, and Last Required)

From: _____

To: _____
(Exact way your name is to appear)

Reason: Correction/Marriage/Divorce/Other: _____

Replacement Wall Certificate

☐ Fee- $35.00 check made payable to "Treasurer-Sate of NH"

Replacement License Pocket Card

☐ Fee - $5.00 - make check made payable to "Treasurer-State of NH"
No charge when making a name change

_____
Signature Date

Please fax or forward this form to: **Office of Licensed Allied Health Professionals**
2 Industrial Park Drive
Concord NH 03301
Phone: (603) 271-8389 Fax: (603) 271-6702