Texas Medical Board
Mailing Address: PO Box 2029, MC-245, Austin, Texas 78768-2029
Phone: (512) 305-7030

APPLICATION FOR NAME CHANGE

Please print or type your information:

License information:	License type License number
Full name as it appears on your current permit:	First name Middle name Last name
Indicate how your name is to be shown on your new permit:	First name Middle name Last name
Check reason for name change request:	❒Court Order ❒Marriage ❒Divorce ❒Naturalization ❒Correction ❒Other
You must furnish one of these documents for the name change to be processed. Check the box describing the documents you are providing:	❒A certified or notarized copy of the court order. ❒A certified or notarized copy of your marriage license. ❒A certified or notarized copy of your divorce decree (only include applicable pages). ❒An original naturalization certificate for inspection, which will be returned to you by certified mail. ❒For name change correction only, a copy of your birth certificate. ❒ **Please check here if you are requesting that the documents submitted need to be returned to your mailing address.**
Definitions:	Notarized copy is a full, true, and correct photographic copy of the original record with an original notary stamp and signature. Certified copy is original copy of the document certified by the County Records Office where the marriage license was issued or the court order or divorce was filed.
Email contact information:	

I certify that all statements I have made herein are true to the best of my knowledge.

_____

Signature of applicant Date

Please note that this form must be submitted with an original signature for a request to be completed. A new permit will be mailed separately after the name change has been processed. Please use the attached address update sheet as needed.

Texas Medical Board
Mailing Address: PO Box 2029, MC-245, Austin, Texas 78768-2029
Phone: (512) 305-7030

APPLICATION FOR NAME CHANGE
ADDRESS UPDATE

Please keep this Board informed of any changes in your addresses. This will ensure receipt of your renewal notices and permits, as well as other Board correspondence.

Please print or type your new information:

Name: _____

License Number: _____

MAILING ADDRESS:	PRACTICE ADDRESS:
_____	_____
Street or P O Box	Street
_____	_____
Suite or Room No.	Suite or Room No.
_____	_____
City, State, Zip	City, State, Zip

Date change becomes effective: _____

Signature (Required)**:** _____.
Signature **Date**

Mail to: Texas Medical Board
P.O. Box 2029, MC 245
Austin, Texas 78768-2029