



Arizona Board of Osteopathic Examiners In Medicine and Surgery

1740 W. Adams Street, Suite 2410, Phoenix, Arizona, 85007

Ph : 480-657-7703 | Fx: 480-657-7715 | www.azdo.gov | questions@azdo.gov

NAME CHANGE REQUEST FORM

To request a name change, send this completed form and documentation by email, fax or mail to the Board of Osteopathic Examiners in Medicine and Surgery using the contact information above.

1. Complete the following information:

License Number: _____

Previous Full Legal Name: _____

Present Full Legal Name: _____

Reason for name change: _____

2. Provide Copy of Name Change Document(s):

Please attach a copy of the legal document(s) verifying change of name. For example, a marriage certificate, page from a divorce decree re-instating legal name, or other legal documents. No change will be made to your profile until the proper documentation has been received.

3. Request Wall Certificate (If applicable):

If you wish to receive a new wall certificate, please submit a \$10 fee along with your request. A credit card payment form is available on our website at www.azdo.gov > For DOs > Other Forms.

4. Update Addresses (If applicable): If you have moved, you may update your address(es) below.

Address of Record/Practice Address. This address & phone number is required by ARS § 32-1803(4)(b), and shows on the Board's website. This address will be your mailing address unless you designate otherwise in the residential address box to the right.	Residential Address. <input type="checkbox"/> By checking this box I am requesting the Board use my residential address as my mailing address. If you do not provide a practice address, your home <u>city and state only</u> will show on the Board's website (ARS § 32-1800(2)(b) & ARS § 32-3801).
Name of Practice:	Street Address:
Street Address:	City, State, Zip:
City, State, Zip:	Home Number:
Office Number:	Cell Number:
Fax Number:	Email Address:

5. Sign and Date request.

The licensee's signature is required in order to process this request.

Licensee Signature: _____ Date: _____