



MISSISSIPPI STATE DEPARTMENT OF HEALTH

Bureau of Professional Licensure

NAME CHANGE REQUEST FORM

Instructions: Complete this form and submit it with a copy of the legal document supporting your name change (driver's license, marriage certificate, divorce decree, court order, or other legal documentation) via mail or email.

LICENSE INFORMATION

License Type: _____

License Number: _____

CURRENT NAME ON LICENSE

First Name: _____

Middle Name: _____

Last Name: _____

REQUESTED LEGAL NAME

First Name: _____

Middle Name: _____

Last Name: _____

CONTACT INFORMATION – any changes to the following information will be updated

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Email Address: _____

SUPPORTING DOCUMENTATION (Check One) – please attached copy of supporting documentation when submitting for a name change request

- Marriage Certificate
- Divorce Decree
- Driver's License
- Social Security Card

APPLICANT CERTIFICATION

I hereby request that my licensure records be updated to reflect my legal name. I certify that the information provided is true and correct and that supporting documentation is attached.

Applicant Signature: _____

Date: _____

Email: MSDHProfLicensure@msdh.ms.gov

Mailing Address:

MSDH Professional Licensure
PO Box 1700
Jackson, MS 39215