



MEDICAL BOARD OF CALIFORNIA
Licensing Program

NOTIFICATION OF NAME CHANGE

Please indicate license type below:

- Physician & Surgeon []
Midwife []
Spectacle Lens Dispenser/Contact Lens Dispenser []
Research Psychoanalyst []

FOR OFFICE USE ONLY
Date Received: _____
Enforcement Approval: ___ Yes ___ No
Date of Approval: _____
Date Completed: _____

IMPORTANT: On the first line of the declaration you MUST list the name as it appears on your current license/registration.

DECLARATION

I, _____ (First) _____ (Middle) _____ (Last) (exactly as it appears on your current license/registration)

hereby certify that I was originally issued and currently hold license/registration number(s) _____ to practice in the State of California.

I further certify I have assumed the name of:

_____ (First) _____ (Middle - limit of 12 characters) _____ (Last)

based on one of the following:

- Court Order [] Marriage [] Naturalization [] Dissolution of Marriage []

Other (Please specify) _____

You MUST submit an original certified copy of the legal documentation with this form. Examples of acceptable forms of legal documentation are:

- Marriage Certificate • Divorce Decree • Court Documents • Naturalization Certificate
• Birth Certificate • Social Security Card • Passport

Your request for a name change cannot be processed without supporting documentation. All original documents will be returned by certified mail.

If you need a wall certificate or wallet license printed with your new name, you must submit an Application for Duplicate Certificate Form (07L-38), available on the Board's Web site at www.mbc.ca.gov.

BOTH PAGES OF THIS FORM MUST BE COMPLETED.

<p><u>PHOTO AREA</u></p> <p>PASTE A PASSPORT TYPE PHOTO HERE.</p> <p>PHOTO MUST BE RECENT AND MUST BE OF YOUR HEAD AND SHOULDER AREAS ONLY WITH CLEAR VIEW OF FACE.</p> <p>ALTERED PHOTOS ARE NOT ACCEPTABLE.</p>	<p>NOTICE: All items in this application are mandatory; none is voluntary. Failure to provide any of the requested information will result in the application being rejected as incomplete. The information provided will be used to identify the licensee and to verify the licensee's identification under Section 2081 of the Business and Professions Code. Licensees have the right to review their application file subject to the provisions of the Information Practices Act. The chief of the Licensing Program is the custodian of records. Information in this application may be transferred to other governmental and law enforcement agencies.</p>
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Address of Record (current public/mailling address) This is the address that will be displayed on the Medical Board's Web site. If listing a PO Box, you also must provide a confidential street address.

Address: _____

City: _____ State: _____ Zip: _____

Confidential Street Address:

Address: _____

City: _____ State: _____ Zip: _____

Telephone number: _____ **Fax number:** _____

E-mail: _____

AFFIDAVIT

I hereby declare under penalty of perjury under the laws of the State of California that the information provided on this form, including supporting documentation and photograph of me, is true and correct and that I am licensed/registered to practice in the State of California. I further certify that this is my new, adopted name for all purposes, and this name change has not been made for fraudulent purposes.

Applicant's Signature _____
Date

<p>State of _____</p> <p>County of _____</p> <p>Subscribed and sworn to (or affirmed) before me on</p> <p>this _____ day of _____, 20____,</p> <p>by: (applicant's name printed here) _____</p> <p>proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.</p>	<div style="border: 1px solid black; width: 100px; height: 100px; margin: 0 auto; text-align: center; line-height: 100px;">NOTARY SEAL</div> <p style="text-align: center;">_____ Signature of Notary Public</p>
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