

FORM AD/NAME

MD BOARD OF CHIROPRACTIC AND MASSAGE THERAPY EXAMINERS

4201 Patterson Ave., Suite 301, Baltimore, MD 21215  
Chiropractic 410-764-4726 – Massage 410-764-4738

OFFICE USE

# ADDRESS/NAME CHANGE FORM

## INSTRUCTIONS

Use this form to report a change in your address and/or name. Please read these instructions carefully and be sure you complete the appropriate sections of this form. Please print clearly in ink

- **FOR ADDRESS CHANGE ONLY:** Complete Sections I, II, and IV. You must mail this form to the Board to the address above.
- **FOR NAME CHANGES ONLY:** Complete Sections I, III, and IV. **NAME CHANGES** must be accompanied by supporting documentation.

Acceptable supporting documentation includes:

A court order authorizing your name change, marriage certificate, or divorce papers AND a copy of a photo ID in your new name.

**OR**

**TWO (2)** of the following:

- A letter from the Social Security Administration indicating both your old and new names.
- Copies of both old and new driver's licenses.
- Copies of both old and new Social Security Cards.
- Copies of both old and new passports.
- Copies of both old and new U.S. Military photo ID cards.

Be sure to sign and date section IV. FOR NAME CHANGE ONLY: You must remit back to the Board both parts of your current License or Registration for a REPLACEMENT in your new name.

- **FOR ADDRESS AND NAME CHANGES:** Complete all sections.

**NOTE:** Important information and license/registration renewals will be sent to the address on file for you. **You Must Notify the Board in writing (this form) within 60 days if your address changes (COMAR 10.43.17.06(B), 10.43.17.07(B), 10.43.01.05(F)-Penalties: 10.43.06.02 & .03) and if your name changes.**

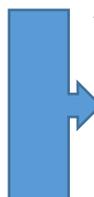
### Section I: Your General Information

1. Name (currently on record): \_\_\_\_\_
2. Social Security No. \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Telephone: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_  
E-mail: \_\_\_\_\_ Fax: \_\_\_\_\_
3. Are you reporting an address and/or name change?  address change  name change  both
4. Effective date of change: \_\_\_\_\_ (Note: Changes cannot be accepted until after the effective date.)

### Section II: Address Change (please type or print)

#### Information CURRENTLY On Record

Apt./Bldg. \_\_\_\_\_  
 Street \_\_\_\_\_  
 City \_\_\_\_\_  
 State \_\_\_\_\_ Zip Code \_\_\_\_\_



#### NEW INFORMATION

Apt./Bldg. \_\_\_\_\_  
 Street \_\_\_\_\_  
 City \_\_\_\_\_  
 State \_\_\_\_\_ Zip Code \_\_\_\_\_

**IS THIS NEW ADDRESS CHANGE A BUSINESS ADDRESS?**  YES (add business name)  NO

(page 1 of 2)

**Section III. Name Change (please type/print).** If you are reporting a name change, please sign using your **NEW** name in Section IV. Ensure that you have attached the required documents indicated on page 1 of this form **AND** your **ORIGINAL** current license/registration in order for your name change to be process. **FAILURE TO FOLLOW THE DIRECTIONS AS INDICATED MAY RESULT IN YOUR SUBMISSION BEING RETURNED TO YOU AND YOUR LICENSE/REGISTRATION BEING DELAYED.**

**IF YOU HAVE QUESTIONS, PLEASE CONTACT THE BOARD.**

**Information CURRENTLY On Record**

**NEW INFORMATION**

**NAME**

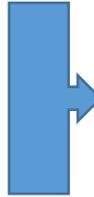
**NAME**

LAST \_\_\_\_\_

LAST \_\_\_\_\_

FIRST \_\_\_\_\_

FIRST \_\_\_\_\_



**Section IV. AFFIDAVIT**

*I declare and affirm that the statements in page 1 and 2 are true, complete, and correct. I understand that any false or misleading information in, or in connection with, my application or this notification may be cause for denial or loss of licensure and may result in criminal prosecution.*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

**CHECK YOUR LICENSURE CATEGORY:**

- CHIROPRACTOR (D.C.)**
- REGISTERED CHIROPRACTIC ASSISTANT (C.A.)**
- CHIROPRACTIC ASSISTANT TRAINEE (*No licensure status*)**
- LICENSED MESSAGE THERAPIST (LMT)**
- REGISTERED MESSAGE PRACTITIONER (RMP)**