MARYLAND BOARD OF PHYSICIANS
P.O. BOX 37217, BALTIMORE, MD 21297
410-764-4705; 1-800-492-6836, ext 4705

FOR BANK USE ONLY
DATE: ____/____/_____
CHECK NUMBER: _____
AMT PAID: $_____
NAME CODE: _____
APPID: 51 Fee: $25.

APPLICATION FOR ALLIED HEALTH NAME CHANGE

Instructions:

1. Complete this application including notary.
2. Select reason for name change and attach copies of certified document(s) supporting the name change: (i.e., marriage certificate, divorce decree): a. Marriage b. Divorce c. Legal/Court Order
3. Include your check or money order for $25.00 payable to the Maryland Board of Physicians. Mail application and fee to address at the top of this page.

Identifying Information:

License Number

Social Security Number (For ID purposes only) ___-___-____

Date of Birth (mmddyear)

Last Name and Generational Indicator (Jr., III, etc.)

First Name and Middle Name/ Initial

Address (Street Address 1)

Address (Street Address 2)

Telephone Number: ___--___--____

Email Address:

City

State

Zipcode

Change Name To Read As Follows:

Last Name and Generational Indicator (Jr., III, etc.)

First Name and Middle Name/Initial

This Form MUST Be Notarized

I solemnly affirm under the penalties of perjury that the contents of the foregoing paper are true and correct to the best of my knowledge, information and belief.

Signature: _____

Date: _____/_____/_____

Notary Public

Date: _____/_____/_____

City/County of Residence: _____

Commission Expires: _____/_____/_____

Notary Signature: _____