



## NOTIFICATION OF NAME CHANGE

The Speech-Language Pathology & Audiology & Hearing Aid Dispensers Board may recognize a name change by a licensee if that name is now their legal name for all purposes and if the change is not made for fraudulent purposes and is not misleading to the public. If you would like replacement certificates to reflect your new name, please complete Part II of this form and submit a \$25.00 fee per document.

Please allow 10 business days for processing of the name change to appear on the website. Replacement licenses will be mailed within 3-4 weeks of initial request date. \*Replacement licenses are not issued to Aides.

### PART I: Please print or type:

**NAME:** (Please provide name license was issued under) \_\_\_\_\_  
(First, Middle, Last)

**LICENSE TYPE:** (Check one)  SP  AU  DAU  HA  SPA  RPE  AIDE

**LICENSE NUMBER:** \_\_\_\_\_ **CONTACT PHONE #:** \_\_\_\_\_  
(Please include area code).

**ADDRESS OF RECORD:** \_\_\_\_\_  
(Street)  
\_\_\_\_\_  
(City, State, Zip Code)

### REASON FOR NAME CHANGE:

- Marriage – Please attach a copy of the marriage certificate or updated California Driver's License.  
 Dissolution or Legal Separation - Please attach a copy of the court order.  
 Other: \_\_\_\_\_ Please attach appropriate supporting documentation.  
(You must provide appropriate supporting documentation in order to complete the name change).

### DECLARATION:

I, \_\_\_\_\_ (First Name) certify that I was originally issued and currently hold license number \_\_\_\_\_  
to practice in the state of California under the name of \_\_\_\_\_  
(First) (Middle) (Last)  
I further certify that I have now assumed the name of \_\_\_\_\_  
(First) (Middle) (Last)

### PART II: REQUEST FOR REPLACEMENT DOCUMENT (Documents being replaced must be returned with this form).

#### SELECT THE LICENSE YOU ARE REQUESTING: (\$25.00 fee per document)

Original Wall License  Renewal Wall License  Pocket License

I certify under penalty of perjury of the laws of the State of California that I am the person who was issued the original wall and/or pocket certificates by the Speech-Language Pathology & Audiology & Hearing Aid Dispensers Board, for which I am requesting replacements. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_