

**STATE OF ARIZONA
NOTIFICATION OF NAME CHANGE
AS A RESPIRATORY CARE PRACTITIONER**

Please complete and mail this form along with a \$25 processing fee to: Board of Respiratory Care Examiners, 1740 W. Adams St., Suite 3406, Phoenix, AZ 85007. For any questions related to this form, please contact the Board office at licensing@rb.az.gov or 602-542-5995.

NAME CHANGE INFORMATION

Former Name: (first, middle, last)

New Name: (first, middle, last)

Last Four of SSN#:

License #:

Date of Birth (MM/DD/YYYY):

SUPPORTING DOCUMENTATION

You must attach a photocopy or electronic copy of one of the following documents. Check the box of the supporting document you are providing as proof of your name change.

Certified Court Order

Marriage Certificate

Dissolution of Marriage (Divorce)

PERSONAL ATTESTATION

I declare under penalty of perjury under the laws of the State of Arizona that the information given above is true and correct and that I am the person who was issued the original Arizona license by the AZ Board of Respiratory Care Examiners.

I hereby certify that the name change is not made for fraudulent purposes.

Signature (required)

Date

Payment must be made in advance. You may pay by check, cashier's check or money order, payable to "BOARD OF RESPIRATORY CARE EXAMINERS".