

Name Change & Duplication Request Form

STATE MAIL IS NOT FORWARDED TO ANY OTHER ADDRESS AND IT IS RETURNED TO THIS OFFICE.

Licenses shall maintain their current business and home addresses on file with their governing boards. Any changes in address shall be provided to the office **no later than 30 days** from the date of the change. II. Licensees shall notify their governing boards if licenses or other proof of licensure are lost or stolen.

General Information: Please print legibly - This section required for all requests

Name: _____ Social Security #: _____

Profession: _____ License #: _____

Home Mailing Address: (City, State, and Zip Code Required)

For name change, please include duplication of legal documentation. (Marriage License, Divorce Decree, or other legal papers)

Name Change: (First, Middle, and Last Required)

From: _____

To: _____
(Exact way your name is to appear)

Reason: Correction/Marriage/Divorce/Other: _____

Replacement Wall Certificate

Replacement License Pocket Card

Signature

Date

Please fax or forward this form to: **Board of Ophthalmic Dispensers**
Philbrook Building, 121 South Fruit Street
Concord NH 03301
Phone: (603) 271-9254 Fax: (603) 271-6702