CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR

SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY & HEARING AID DISPENSERS BOARD
1601 Response Road, Suite 260, Sacramento, CA 95815
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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 a license to reflect your new name, please complete Part II of this form and submit a $25.00 fee per document. Make check or money order payable to SLPAHADB. All licensees are permitted one wall license and one pocket license. The documents being replaced must be returned with this form. Replacement licenses are not issued to Aides.

NOTE: Do not use this form for a name change as a result of a gender change. Please complete the *Notification of Name/Gender Change and Request for Confidentiality* at https://www.dca.ca.gov/licensees/namegender_form.pdf.

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 (Public Information): _____
(Street

Would you like your address of record changed?

☐ YES ☐ NO

_____
(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, _____ certify that I was originally issued and currently hold license number _____
(First Name)

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 licenses 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:** _____