

Arkansas Department of Health
Massage Therapy Section
4815 West Markham, Slot #8
Little Rock, AR 72205
Phone: (501) 683-1448
Fax: (501) 682-5640

Name Change/Address Change/Duplicate Request

All changes must be submitted in writing

Name: _____ License #: _____

Type of change requested: (Choose all that apply)

Payment must be payable to ADH-Massage Therapy

Duplicate(s) Certificate _____ Pocket Card Name Change & New License
 (Documentation Required & \$10.00) (Documentation Required & \$10.00) (Documentation Required & \$10.00)

Name Change Only Phone Number Physical/Mailing Address Business Address

Residence Address:

Street Address	Apt. #	City	State	Zip

Business Address:

Business Name: _____				
Street Address	Apt. #	City	State	Zip

Mailing/Other address if different from residence/business:

PO Box/Street House #	Apt. #	City	State	Zip

Phone #: _____ Business Phone #: _____
 Fax #: _____ Cell Phone #: _____

Name changes require legal documentation showing the name change. Valid government issued photo identification is required. Please make sure that a Photocopy of the following accompanies the request:

1. Copy of state issued driver's license with current name and address; or
2. Other form of government issued identification with current name and address.

You must return your current license for a new license to be issued in your new name.

From: _____
 Last Name First Name Middle Name

To: _____
 Last Name First Name Middle Name

Signature _____ Date _____