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

Type of change requested: (Choose all that apply)

☐ Duplicate(s) Certificate_____ (Documentation Required & $10.00)

☐ Pocket Card (Documentation Required & $10.00)

☐ Name Change & New License (Documentation Required & $10.00)

☐ Name Change Only

☐ Phone Number

☐ Physical/Mailing Address

☐ Business Address

Applicant Information:

Last Name	First Name	Middle Name	License Number

Residence Address	Apt #	City	State	Zip Code

Social Security Number	Date of Birth	Email Address

Business Address	Suite #	City	State	Zip Code

Mailing Address	Suite/Apt #	City	State	Zip Code

Phone Number	Business Phone Number	Cell Phone Number	Fax Number

Name Change:

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.

From: _____
Last Name First Name Middle Name

To: _____
Last Name First Name Middle Name

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

By signing this form, I certified that the information provided is correct to the best of my knowledge. Further, I understand that false statements will be sufficient grounds for the Massage Therapy Technical Advisory Committee to take disciplinary action.

Printed Name	**Signature**	**Date**