

Nevada State Board of Medical Examiners
9600 Gateway Drive, Reno, NV 89521
Phone: (775) 688-2559; (888) 890-8210 (Toll-Free)
Fax: 775-688-2321

NOTIFICATION OF NAME CHANGE

Please complete and mail this form to: Nevada State Board of Medical Examiners
9600 Gateway Drive, Reno, NV 89521

Nevada License No.: _____

Old Name: _____
(First) (Middle) (Last)

New Name: _____
(First) (Middle) (Last)

You must submit a copy of a photo ID, along with a copy of the legal document pertaining to the name change (marriage certificate, divorce decree, etc.), with your request in order to verify your identity to ensure your information is released only to you.

PLEASE NOTE: If you wish to obtain a replacement wall certificate in your new name, please complete the information above and enclose the proper fee (*no fee for name change only*):

Replacement Wall Certificate.....\$25.00

If requesting a replacement wall certificate, please indicate the address to where you would like the replacement wall certificate mailed:

Payment must be made in advance. You may pay cashier's check or money order, payable to "NEVADA STATE BOARD OF MEDICAL EXAMINERS," or by credit card. The Board cannot accept personal or business checks. If paying by credit card, please complete the Credit Card Authorization Form on the last page of this order form. A non-refundable card payment-processing fee of 2.5% will be assessed by our payment processor for payment by credit card.

Signed: _____

Dated: _____

THIS FORM MUST BE SIGNED AND DATED BY THE LICENSEE.

CREDIT CARD AUTHORIZATION FORM

*If mailing or faxing this page separately from an application or order form, please mail to:
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
or fax to: 775-688-2321*

Please type or print legibly.

Method of Payment: MasterCard / Visa / American Express / Discover

Name on Credit Card: _____

Business Name (if applicable): _____

Credit Card Billing Address:

Phone Number: _____

Name of Applicant (if applying for licensure): _____

Credit Card Number: _____

Expiration Date: ____ / ____
(MM) (YYYY)

Credit Card Verification Code (CVC): ____
(Three or four digit code found on the front or back of the card)

For security of your financial information, please do not email this form to the Board; emailed forms will not be accepted.

I authorize the Nevada State Board of Medical Examiners to charge the above credit card for a

One-time payment in the amount of \$_____.

Printed Name: _____

Authorized Signature: _____ Date: _____

Email Address for receipt: _____

Disclosure: By continuing, you will be charged a non-refundable card payment-processing fee of 2.5% for debit and credit cards by our payment processor. If you do not wish to pay the fee, you can select another payment option.