

# NAME/ADDRESS CHANGE

Please complete this form and submit a copy of identification with your current name. Approved documentation includes marriage license, divorce decree, social security card, or driver's license with your current name. Please enter your license number to indicate your license type:

LICENSE NUMBER \_\_\_\_\_ Speech – Language Pathologist  
\_\_\_\_\_ Audiologist  
\_\_\_\_\_ Dietitian  
\_\_\_\_\_ Adult Care Home Administrator  
\_\_\_\_\_ Operator

Social Security Number: \_\_\_\_\_ Birthday: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First Middle

Previous Name: \_\_\_\_\_

Current Mailing Address: \_\_\_\_\_  
City/State Zip

Phone Number: (H) \_\_\_\_\_ (C) \_\_\_\_\_ (W) \_\_\_\_\_

Email: \_\_\_\_\_

A printable verification of your license which would verify your new name can be obtained at no cost at [www.kdadslicenseverification.org](http://www.kdadslicenseverification.org)

If you would prefer a new pocket care be printed please indicate below and include payment in the amount of \$10.00 payable to KDADS.

\_\_\_\_\_ I am requesting a new pocket card be printed and have enclosed the required \$10.00 fee.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please mail to KDADS Health Occupations Credentialing 612 S Kansas Ave Topeka KS 66603 or email [wendy.davis@ks.gov](mailto:wendy.davis@ks.gov)