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

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