

Michigan Department of Community Health  
**Bureau of Health Professions**

P.O. Box 30670  
 Lansing, MI 48909  
 517-335-0918  
 Fax 517-373-2179  
 www.michigan.gov/healthlicense

Board Use Only

**DATA CHANGE/DUPLICATE LICENSE REQUEST**

Authority: Public Act 368 of 1978, as amended.

**PHARMACY STORES AND MANUFACTURER/WHOLESALE/DISTRIBUTORS** DO NOT USE THIS FORM FOR A NAME OR ADDRESS CHANGE. YOU WILL NEED TO COMPLETE A RELOCATION APPLICATION WHICH CAN BE OBTAINED EITHER ONLINE AT WWW.MICHIGAN.GOV/HEALTHLICENSE OR BY CONTACTING THIS OFFICE.

**NURSE AIDES** DO NOT USE THIS FORM. YOU NEED TO CONTACT PROMETRIC AT 1-800-752-4724 TO OBTAIN THE PROPER FORM FOR NAME AND/OR ADDRESS CHANGE.

Address changes can also be processed on-line by visiting our website at [www.michigan.gov/mylicense](http://www.michigan.gov/mylicense). However, please use this form when requesting a name change.

**Type or Print Only**

Current Information on License/Registration:

First Name	Middle Name	Last Name
Profession		MI Permanent I.D. Number
E-Mail Address		
U. S. Social Security Number	Date of Birth	Phone Number

**Please check the boxes below for the service you are requesting:**

Please specify which licenses/registrations you want changed. **NO CHANGES WILL BE MADE IF THIS FORM IS NOT COMPLETE.**

- Professional License/Registration    
  Controlled Substance    
  Specialty License    
  Drug Control

1. **NAME CHANGE:** I request the Department to change my records due to a name change. A **copy** of the legal document (i.e. **marriage certificate, divorce decree or other form of legal documentation**) must be submitted, with this form, to verify the name change you are requesting. Your signature must be provided on reverse side. If you would like a new license reflecting your new name, please see fee requirement on reverse side.

New Name: \_\_\_\_\_  
 (Print Clearly)                                      Last                                      First                                      Middle

Reason for Change: \_\_\_\_\_

2. **ADDRESS CHANGE FOR PROFESSIONAL AND/OR SPECIALTY:** I request the Department to change my record due to an address change. Your signature must be provided on reverse side. If you would like a new license reflecting your new address, please see fee requirement on reverse side.

Name of Office/Facility:  
 (If applicable) \_\_\_\_\_

Address: \_\_\_\_\_

City, State and Zip Code: \_\_\_\_\_

Phone Number w/Area Code: \_\_\_\_\_

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

3. **ADDRESS CHANGE FOR CONTROLLED SUBSTANCE AND DRUG CONTROL LICENSE:** I request the Department to change my record due to an address change. Your signature must be provided below. If you would like a new license reflecting your new address, please see fee requirement listed below.

MI Permanent I.D. Number: \_\_\_\_\_

Name of Facility or Office: \_\_\_\_\_

Facility or Office Address: \_\_\_\_\_

City, State and Zip Code: \_\_\_\_\_

Phone Number w/Area Code: \_\_\_\_\_

4. **DUPLICATE LICENSE \$10.00 for each license:** I request the Department to issue a duplicate for the following reason:

- Data Change                       Lost                                       Stolen                                       Not received                                       Destroyed

Please check **below** the license(s) you are requesting a duplicate to be issued. Make your check payable to the State of Michigan for the total amount.

- Professional License/Registration - \$10.00                       Specialty License - \$10.00
- Controlled Substance - \$10.00                                       Drug Controlled - \$10.00

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this request.. **DO NOT SEND CASH.** Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

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

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