



Federation of State Medical Boards (FSMB)
 Examination Services: Name Change
 P.O. Box 619850
 Dallas, Texas 75261-9850
 Telephone (817) 868-4041
 Fax (817) 868-4098

Name Change Authorization Request Form

To change your name on your official FSMB record, the FSMB requires this signed authorization form and evidence that substantiates the change, showing that you are using your new name consistently. The following documents are acceptable:

1. A copy of a non-expired, government issued document bearing your new name, signature and photograph (e.g., driver's license or passport).

Please complete this form (**type or print**) and mail or fax to the above address with the required documentation. Telephone calls or emails are not accepted for this purpose.

YOUR NAME WILL NOT BE CHANGED IN OUR RECORDS UNTIL WE RECEIVE THIS FORM AND THE REQUIRED DOCUMENTATION.

USMLE Identification # (if known) _____ Date of Birth _____ Social Security or National Identification # _____

Phone Number (Daytime) _____ Phone Number (secondary) _____ E-mail Address _____

Current name on record:

Last Name _____ First Name _____ Middle Name _____

I request and authorize the FSMB to change my name on the official record to:

Last Name _____ First Name _____ Middle Name _____

My name change became effective on ____/____/____, for the following reason:
Month / Day / Year

Marriage Divorce Other (please explain): _____

I certify that the information I have submitted to the FSMB is true and accurate and authorize the FSMB to update their records according to the information I have provided.

Signature: _____ Date: ____/____/____
Month / Day / Year