MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE
REQUEST FOR NAME CHANGE
$100 FEE REQUIRED

Completed form can be submitted to the following address:
Mississippi State Board of Medical Licensure
1867 Crane Ridge Drive, Suite 200-B
Jackson, MS 39216

Original wall certificate must be returned along with a certified copy of official name change.

Practitioner Name			
License No.		Date of Birth	
DEA No.		NPI No.	
Email Address			
Mailing Address (This is where your new wall certificate will be mailed.)		Telephone (h)	
		Telephone (w)	
		Telephone (c)	
Requested New Name			

I, _____, certify after being duly sworn, that all of the information supplied in the Mississippi State Board of Medical Licensure's Request for Name Change is true and correct to the best of my knowledge, that the photograph submitted herein is a true likeness of myself and was taken within sixty (60) days prior to the date of this request. I acknowledge that any false or untrue statement or representation made in the request may result in the revocation of any license to practice medicine granted to me and criminal prosecution to the fullest extent of the law.

Practitioner Signature		Date	

County of _____

State of _____

SWORN to and subscribed before me this _____ day of _____, in the year of _____.

_____
Notary Public

My Commission Expires:_____

(SEAL)

Attach a Passport-Type

Photograph

Taken Within 60 Days.

Informal Snapshots