

Department of Community Health  
 EMS and Trauma Systems Section  
 P.O. Box 30437  
 Lansing, MI 48909  
 (517) 241-0179

Website: [www.michigan.gov/ems](http://www.michigan.gov/ems)

**DATA CHANGE/DUPLICATE LICENSE REQUEST**

Authority: Public Act 368 of 1978, as amended.

<b>State Office Use Only</b>

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH.** Fees are deposited upon receipt and are **NON-REFUNDABLE.**

**Instructions: Type or print only. Sign and return this form to the address listed above. Changes will not be made unless this form is signed.**

Current Name on License: _____		
Last	First	Middle
EMS License Number: _____		
Date of Birth	Phone Number	U. S. Social Security Number

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

<input type="checkbox"/>	<p><b>1. NAME CHANGE:</b> You must attach a copy of the document legally changing your name. I request the Department to change my records due to a name change. Signature must be provided.</p> <p><b>New Name:</b> _____                  (Print Clearly)                      Last                                      First                                      Middle</p> <p>Reason of Change: _____</p>
<input type="checkbox"/>	<p><b>2. ADDRESS CHANGE:</b> I request the Department to change my record due to an address change.</p> <p>Address: _____                  _____</p> <p>City, State and Zip Code: _____</p>
<input type="checkbox"/>	<p><b>3. DUPLICATE LICENSE:</b> I have enclosed the required fee of \$10.00 for the license that I am requesting the Department to issue a duplicate for. Please check the reason why you are requesting the duplicate license:</p> <p style="text-align: center;"> <input type="checkbox"/> Data Change                          <input type="checkbox"/> Lost                          <input type="checkbox"/> Stolen                          <input type="checkbox"/> Not received                          <input type="checkbox"/> Destroyed                 </p> <p><b>You will <u>not</u> receive notification of the changes(s). You can check our web site after two weeks to confirm the change by selecting the “verify a license” link at <a href="http://www.michigan.gov/ems">http://www.michigan.gov/ems</a></b></p>
Signature: _____	Date: _____

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs know to this agency