

Michigan Department of Licensing and Regulatory Affairs  
**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.

**Current Information on License/Registration:**

Type or Print Only

First Name	Middle Name	Last Name
Profession		MI Permanent I.D. Number
U. S. Social Security Number	Date of Birth (MM/DD/YYYY)	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     
  Control Substance     
  Specialty License  
 Drug Control     
  Drug Treatment Prescriber

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)**

First Name	Middle Name	Last Name
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):

Street Address:

City:	State:	Zip Code:
Phone number w/ Area Code: (      )	E-mail Address:	

Name:		
<input type="checkbox"/> 3. <b>ADDRESS CHANGE FOR CONTROLLED SUBSTANCE AND DRUG CONTROL LICENSE:</b> 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 Office/Facility:		
Street Address of Office/Facility:		
City:	State:	Zip Code:
Phone number w/ Area Code: (       )	E-mail Address:	

<input type="checkbox"/> 4. <b>DUPLICATE LICENSE \$10.00 for each license:</b> I request the Department to issue a duplicate for the following reason:				
<input type="checkbox"/> Data Change	<input type="checkbox"/> Lost	<input type="checkbox"/> Stolen	<input type="checkbox"/> Not received	<input type="checkbox"/> Destroyed
<b>If your license will expire in the next 60 days, you do not need to pay for a duplicate license. You will receive a new license after the renewal is processed.</b>				
Please check <b>below</b> the license(s) you are requesting a duplicate to be issued. Make your check payable to the State of Michigan for the total amount.				
<input type="checkbox"/> Professional License/Registration - \$10.00	<input type="checkbox"/> Specialty License - \$10.00			
<input type="checkbox"/> Controlled Substance - \$10.00	<input type="checkbox"/> Drug Control - \$10.00	<input type="checkbox"/> Drug Treatment Prescriber - \$10.00		
Your check or money order drawn on a U.S. financial institution and made payable to the <b>STATE OF MICHIGAN</b> must accompany this request. <b>DO NOT SEND CASH.</b> Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.				

Signature:	Date:
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