STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Emergency Medical Services

NAME/ADDRESS CHANGE REQUEST

Print/Type clearly the information requested:

License Number: _____ Profession: _____ SSN: _____

Information as it is **NOW SHOWN** on your license:	**Print/Type the information as you wish it to appear on your new license:**
Last Name:_____	Last Name:_____
First Name:_____ MI: _____	First Name:_____ MI: _____
Street Address 1:_____	Street Address 1:_____
Street Address 2:_____	Street Address 2:_____
Apt/Suite:_____	Apt/Suite:_____
City: _____ State: _____	City: _____ State: _____
Postal Code:_____	Postal Code:_____
Email Address: _____	Email Address: _____

I declare that the information provided herein is a truthful and complete statement of the information requested.

Signature: _____

Telephone No.: _____

Date: _____

Please return completed form and all supporting name change verification documentation by clicking on the button. Forms can also be sent via fax or mail to the below address:

Connecticut Department of Public Health
410 Capitol Ave., MS# 12 EMS
P.O. Box 340308
Hartford, CT 06134
Fax: 860-920-3142
Phone: 860-509-7975 x1
dph.emslicensing@ct.gov

Click to submit