



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: _____

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