

LIBERTY UNIVERSITY

COLLEGE of OSTEOPATHIC MEDICINE

Office of the Registrar

Name Change Request Form

Student Information (Please Print)

Liberty Student ID: _____ Date of Birth (mm/dd/yy): ____/____/____

Previous Name: _____
(First) (Middle) (Last)

New Legal Name: _____
(First) (Middle) (Last)

Email: _____ Phone Number: (____) _____ - _____

Are you currently enrolled? Yes No: Last Date Attended: _____

Special Instructions and Information

This request form must be accompanied by an **updated Social Security Card AND** one of the below legal documents verifying your new name.

Additional Legal Documentation Attached:

- Marriage Certificate
- Divorce Decree
- Legal Name Change Certificate
- Newly Issued Passport
- Newly Issued Driver's License

Update Address:

Address: _____

- Permanent
- Mailing

Authorization (Please Print & Sign)

Student's Signature: _____ Date: _____

**By signing this form you authorize the LUCOM Registrar's Office to send your transcript(s) to the designated person or organization listed above, and you agree to the applicable charges.*

Contact Information & Instructions

Submit Request(s) to:

College of Osteopathic Medicine
Registrar's Office
1971 University Drive, Lynchburg, VA 24515
Tel. (434) 592-6954 · Fax (434) 582-3878 · lucomregistrar@liberty.edu

*Allow 3-5 business days for processing.

Registrar's Use Only

Processed By: _____ Date: _____