

NAME CHANGE REQUEST FORM

(For Licensed Nurses Only)

Please type or print using CAPITAL LETTERS and black ink.

\$25 FEE
(NON-REFUNDABLE)

Section 1: Old Biographical Data (Licensed Nurse)

Last Name (print clearly)

First Name (print clearly)

Full Middle Name (print clearly)

Maiden Name (print clearly)

____ - ____ - ____ / ____ / ____

Social Security # (print clearly) Date of Birth (print clearly) KY License # (print clearly)

Indicate your license type(s) [check all that apply]: RN LPN APRN SANE

Section 2: New Name Change (Licensed Nurse)

Last Name (print clearly)

First Name (print clearly)

Full Middle Name (print clearly)

Maiden Name (print clearly)

Street (print clearly)

_____ - _____

City (print clearly) State Zip Code (print clearly)

County of Residence (print clearly)

_____ - _____

Country, if not U.S.A. (print clearly) International Postal Code (print clearly)

Email Address (print clearly)

____ - ____ - ____ - ____ - ____ - ____

Home Phone (print clearly) Daytime Phone (print clearly)

I declare my state of primary residence to be: Kentucky Other (Specify State) _____

Do you practice nursing ONLY in a military/federal facility? Y N

_____ / ____ / ____

Signature Date

NOTE: KBN DOES NOT ISSUE PLASTIC LICENSE CARDS.

You must enclose a copy of one of the following:

- Marriage Certificate
- Divorce Decree
- Social Security Card
- Legal Name Change Document