



The Commonwealth of Massachusetts  
 Department of Public Health  
**Bureau of Health Professions Licensure**  
 239 Causeway Street • Suite 500, 5<sup>th</sup> Floor • Boston • MA • 02114  
<http://www.mass.gov/dph/boards/pa>  
 (617) 973-0806

**Board of Registration in Physician Assistants**

Use this form to request a name change, address change and/or a duplicate license. Check all that apply:

**NAME CHANGE**       **ADDRESS CHANGE**       **DUPLICATE LICENSE**

**Read the following information carefully before completing form:**

1. If you are requesting a **name change** and you have a current or expired license with another board within the Bureau, the requested name change will be effective for all boards.
2. All addresses are subject to disclosure on request (MGL c. 4, s. 7).
3. You must complete this form and **remit the duplicate license fee for each license** you wish to have duplicated.
4. Check here if your current license has been **lost or stolen** .

**For a name change, you MUST return the original hard copy of your license and submit a copy of supporting documents.**

Check document submitted: \_\_ marriage certificate \_\_ divorce decree \_\_ court documents \_\_ other

**License Number:** PA \_\_\_\_\_ PAT \_\_\_\_\_ **Expiration Date:** \_\_\_\_\_

**Social Security Number (Mandatory):** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

Clearly print or type information as it <b><u>NOW APPEARS</u></b> on your license: <b>Name:</b> _____ <b>Address:</b> _____ <b>City/Town:</b> _____ <b>State:</b> _____ <b>Zip code:</b> _____	Clearly print or type information as you wish it to appear on your <b><u>NEW</u></b> license: <b>Name:</b> _____ <b>Address:</b> _____ <b>City/Town:</b> _____ <b>State:</b> _____ <b>Zip code:</b> _____
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**Other professional licenses held** (check all that apply):

Dentistry    Genetic Counselor    Nursing Home Administrator    Perfusionist    Pharmacy    Physician Assistant    Respiratory Care

**My signature hereon attests under penalties of perjury that the information provided is truthful, complete, and for lawful and honest purposes.**

**Signature:** \_\_\_\_\_

**Daytime Telephone Number:** \_\_\_\_\_

**Date:** \_\_\_\_\_

*Mail request to the Board at the address above.*

<b>FEE(S)</b>	
1. Duplicate license	\$17.00
2. Name change with new license	\$27.00
3. Address changes only	No Fee
4. Name change with renewal	No Fee
Make check or money order payable to the "Commonwealth of Massachusetts." <b>DO NOT SEND          CASH OR ELECTRONIC FUNDS TRANSERS</b>	

<b><u>For Official Use Only:</u></b>	
Check Amount (fee):	_____
Check Number:	_____
MLO Receipt Date:	_____
MLO Receipt Number:	_____
Staff Signature:	_____