



LICENSE PROFILE CHANGE

PLEASE NOTE: ALL INFORMATION MUST BE COMPLETED

Date Submitted: [] [] - [] [] - [] [] [] []

RI Department of Health License Number: _____

Current Name on Health License: _____

Changing Name on Health License To: _____

(If changing your name you must provide legal proof of the anme change, ie. marriage license, divorce decree, etc...)

Date of Birth: [] [] - [] [] - [] [] [] [] Place of Birth: _____

Social Security Number: [] [] [] - [] [] - [] [] [] []

Home Address: _____

City: _____ State: _____ ZipCode: _____

Home Telephone Number: _____ Home Fax Number: _____

Home Email Address: _____

Work Address:

City: _____ State: _____ ZipCode: _____

Work Telephone Number: _____ Work Fax Number: _____

Work Email Address: _____

Indicate the Reason that You are Submitting this Form

Name Change: [] Address Change: [] Lost License: []

If you have changed your name and wish to have a new license printed, you must submit proof of name change, your old license card, and a money order in the amount of \$40.00, made payable to the "Rhode Island General Treasurer".

Changes of address can be faxed to the Rhode Island Department of Health at (401) 222-1751.

If you have lost your license, you must submit a money order in the amount of \$40.00, made payable to the "Rhode Island General Treasurer".

If you are submitting this form with a fee for a new license card, please mail them to: Rhode Island Department of Health, Data Entry Unit, Room 105A, 3 Capitol Hill, Providence, RI 02908

Please allow 3-4 weeks for receipt of the new license card.