



Arizona Medical Board

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Website: www.azmd.gov • E-Mail: questions@azmd.gov

NAME CHANGE FORM

License Number: _____

Full Legal Previous Name: _____

Full Legal Previous Name: _____

Reason for name change: (please attach legal documents)

Mail or fax this form to:

**Arizona Medical Board
1740 W. Adams St. Ste. 4000
Phoenix, Arizona 85007
Fax: (480) 551-2704**

(Signature)

(Date)