Kentucky Board of Nursing
312 Whittington Pky Ste 300
Louisville KY 40222-5172
Web Address: kbn.ky.gov

NAME CHANGE REQUEST FORM

(For Licensed Certified Professional Midwives Only)

Please type or print using CAPITAL LETTERS and black ink.

$25 FEE (NON-REFUNDABLE)

Section 1: Old Biographical Data (LCPM)

Last Name (print clearly)

First Name (print clearly)

Full Middle Name (print clearly)

Maiden Name (print clearly)

XXX – XX - _____
Last 4 Digits of Social Security # (print clearly)

Date of Birth (print clearly)

KY License # (print clearly)

Section 2: New Name Change (LCPM)

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)

Signature

Date

You must enclose a copy of one of the following:

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

Fax or Mail Completed Form To:

Credentials Branch, Attn: LCPM Specialist
Kentucky Board of Nursing
312 Whittington Parkway, Suite 300
Louisville, KY 40222
Fax #: 502-429-3336