

**OREGON PHYSICAL THERAPIST LICENSING BOARD  
NAME CHANGE FORM**

OAR 848-005-0030 requires all licensees to maintain a current home, mailing, and work address, with corresponding telephone numbers and electronic mailing address, on file with the Board at all times. Any change in name, or the address information noted above, must be reported to the Board within 30 days of the event. The notification must be made in writing, and may be submitted to the Board via E-mail, US mail, or by facsimile.

Name changes must be accompanied by supporting documentation that will provide evidence of legal name change; ( i.e. a COPY of a driver's license, a marriage certificate, a social security card or other Court document.)  
Also include a **\$25.00 check or money order** for processing of a duplicate license with the new name.

**NAME:** \_\_\_\_\_  
(Last) (First) (Middle) (Maiden/previous names)

**LICENSE NUMBER:** \_\_\_\_\_ **EFFECTIVE DATE:** \_\_\_\_\_  
**OF CHANGE**

**MAILING ADDRESS:** \_\_\_\_\_  
(Address Line One)  
\_\_\_\_\_  
(Address Line Two)  
\_\_\_\_\_  
(City, State, Zip)

\_\_\_\_\_  
(Private E-mail Address for Board use Only not available to the Public)

\_\_\_\_\_  
(Public E-mail Address available to public upon records request)

**HOME ADDRESS:** \_\_\_\_\_  
(Street Address)  
\_\_\_\_\_  
(City, State, Zip)  
\_\_\_\_\_  
(Phone Number + Area Code) (Cell Number + Area Code)

**WORK ADDRESS:** \_\_\_\_\_  
(Employer Name)  
\_\_\_\_\_  
(Street Address or PO Box)  
\_\_\_\_\_  
(City, State, Zip)  
\_\_\_\_\_  
(Phone Number + Area Code) (Fax Number + Area Code)

**LICENSEE SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**Mail this form with check to:** Oregon Physical Therapist Licensing Board  
800 NE Oregon Street, Suite 407  
Portland, OR 97232-2187  
Phone: (971) 673-0200 Fax: (971) 673-0226  
E-mail [physical.therapy@state.or.us](mailto:physical.therapy@state.or.us)