NEW YORK MEDICAL COLLEGE

A MEMBER OF THE TOURO COLLEGE AND UNIVERSITY SYSTEM

OFFICE OF THE UNIVERSITY REGISTRAR

REQUEST FOR NAME CHANGE

School(s): ☐ School of Medicine ☐ Basic Medical Sciences ☐ School of Health Sciences & Practice

Student ID Number: _____

CURRENT NAME:

_____ _____ _____

First Middle Last

NEW NAME:

_____ _____ _____

First Middle Last

Change my email address with information services ☐ yes ☐ no

No change will be made without this signed and dated request, accompanied by official documentation that supports the name change. Original documentation must be reviewed.

REASON FOR NAME CHANGE:	**ACCEPTABLE DOCUMENTATION**
[ ] Correction [ ] Legal Name Change	● Marriage License ● Divorce Decree ● Court Order ● Birth Certificate ● Passport ● Immigration Papers

_____ _____

Student Signature Date

*Applicants return this form to Admissions
*Continuing students return this form to the Registrar's Office

Office Use ONLY
Processed by:_____ Date:_____
[ ] Admissions SOPH [ ] Admissions GSBMS [ ] Registrar