



## MARYLAND STATE BOARD OF MASSAGE THERAPY EXAMINERS

4201 Patterson Avenue, Suite 301, Baltimore, Maryland 21215

Office Main Telephone: 410-764-4738

Website: <https://health.maryland.gov/massage> Email: [mdh.bcmte@maryland.gov](mailto:mdh.bcmte@maryland.gov)

### OFFICIAL NOTIFICATION OF NAME CHANGE

**Complete all information. Pay the \$40 fee online at: [Massage Therapy Portal](#). After making payment, reply to the receipt email and attach this completed form. Pursuant to Maryland law § 6-305(d), written notification of name and/or address changes must be made to the Board within **60 days** of the applicable change. A **\$100.00 penalty is assessed for failure to comply and must be paid at the same time as the \$40 fee to reissue a license/registration.****

|   |   |   |   |
|---|---|---|---|
| <b>CURRENT INFORMATION<br/>ON FILE WITH BOARD</b>   | NAME (FIRST, MIDDLE, LAST)  | CELL/HOME PHONE:  |   |
|   | BUSINESS NAME (IF APPLICABLE):  | WORK PHONE:   |   |
|   | NON-PUBLIC (Home) ADDRESS   | PERSONAL EMAIL:   |   |
|   | PUBLIC (Business) ADDRESS   | WORK EMAIL:   |   |
|   | WHAT IS YOUR STATUS WITH THIS BOARD? (Check One)  | <input type="checkbox"/> LMT <input type="checkbox"/> RMP   or <input type="checkbox"/> Applicant |   |
|   | LICENSE/REGISTRATION NUMBER:  |   |   |
|   | WHAT DATE DID YOUR NAME LEGALLY CHANGE? (Board Requires Official Documentation)   | <input type="text"/> / <input type="text"/> / <input type="text"/>                                |   |
|   | If more than 60 days, pay \$140 online at <a href="#">Massage Therapy Portal</a>  |   |   |
| NAME CHANGED DUE TO (Check appropriate box): <input type="checkbox"/> MARRIAGE <input type="checkbox"/> DIVORCE <input type="checkbox"/> LEGAL <input type="checkbox"/> OTHER |   |   |   |
| <b>NEW LEGAL NAME</b>   | NEW NAME YOU ARE REPORTING:   | PRONOUN   | HAS YOUR ADDRESS CHANGED  |
|   |   |   | <input type="checkbox"/> YES <input type="checkbox"/> NO                              |
|   | GO TO <a href="http://www.health.maryland.gov/massage">www.health.maryland.gov/massage</a> to access Board Forms<br>IF YOUR ADDRESS HAS CHANGED IN ADDITION TO YOUR NAME.<br>ATTACH THE COMPLETED CHANGE OF ADDRESS FORM. |   | DID YOU COMPLETE THE<br>CHANGE OF ADDRESS FORM?                                       |
|   |   |   | <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO |
| <b>FAILURE TO SUBMIT ALL REQUIRED DOCUMENTS AND THE CORRECT FEES AT ONE TIME WILL<br/>RESULT IN A DELAY IN OBTAINING YOUR NEW LICENSE OR REGISTRATION.</b>                    |   |   |   |
| I attest that the above statements are true to the best of my knowledge.  |   |   |   |
| Signature: _____  |   | Date: _____   |   |

**PLEASE UPLOAD TWO (2) THE FOLLOWING REFLECTING/AUTHORIZING NAME CHANGE WITH THIS FORM:**

- \* Copy of the new driver's license or state issued identification card
- \* Copy of Certificate of Citizenship/Naturalization/Passport
- \* Court order/legal document authorizing name change

- \* Copy of the new social security card
- \* Copy of a valid U.S. Military Photo ID
- \* Copy of the marriage certificate

**Within 10 days of the receipt of your updated license/registration, you are to mail back your current license/registration to the Board.**

#### BOARD USE ONLY

Fee Payment Date: \_\_\_\_\_ Advice #: \_\_\_\_\_ Amount: \_\_\_\_\_ Initials: \_\_\_\_\_  
Lic./Reg No.: \_\_\_\_\_ Control No.: \_\_\_\_\_ Date Issued: \_\_\_\_\_ LC/LUM Init: \_\_\_\_\_  
Control Log-Payment Recon LC/LUM/Designee: \_\_\_\_\_  
Reviewer: \_\_\_\_\_ (ED/LUM/Designee) Date \_\_\_\_\_