



Arkansas

STATE BOARD OF MASSAGE THERAPY

PO Box 2019
Little Rock, AR 72203
Phone: (501) 683-1448
Fax: (501) 683-1426

Name Change/Address Change/Duplicate Request

All changes must be submitted in writing (2010 – 2012 Form)

Name: _____ License #: _____

Type of change requested: (Choose all that apply)

Payment must be in the form of a Cashier's Check or Money Order only - payable to ASBMT

- Duplicate(s) Certificate _____ (Documentation Required & \$10.00)
- Pocket Card (Documentation Required & \$10.00)
- Name Change & New License (Documentation Required & \$10.00)
- Name Change Only
- Phone Number
- Physical/Mailing Address
- Business Address

Residence Address:

Street Address	Apt. #	City	State	Zip

Business Address:

Business Name: _____				
Street Address	Apt. #	City	State	Zip

Mailing/Other address if different from residence/business:

PO Box/Street House #	Apt. #	City	State	Zip

Phone #: _____ Business Phone #: _____
Fax #: _____ Cell Phone #: _____

Name changes require legal documentation showing the name change. Valid government issued photo identification is required. Please make sure that a Photocopy of the following accompanies the request:

1. Copy of state issued driver's license with current name and address; or
2. Other form of government issued identification with current name and address.

You must return your current license for a new license to be issued in your new name.

From: _____
Last Name First Name Middle Name

To: _____
Last Name First Name Middle Name

Signature _____

Date _____