Office of the Registrar, Room 1-212
PO Box 33932
1501 Kings Hwy.
Shreveport, LA 71130-3932
Phone: 318.675.5205
Fax: 318.675.4758
Email: shvreg@lsuhsc.edu

LSU Health SHREVEPORT

Name Change Request Form

Student ID Number: _____ Effective Date: _____

FROM: _____
Last Name First Name Middle Name/Initial

TO: _____
Last Name First Name Middle Name/Initial

Student Birthdate: _____ *Signature: _____
MM/DD/YYYY *By signing this form, I certify that I am the student listed above.

- ***Check the school you attended/attending***:

☐ School of Allied Health Professions BS/MPAS/MOT/DPT/MPH/MCD

☐ School of Graduate Studies MS/Ph.D.

☐ School of Medicine M.D.

- ***Reason for name change***:

☐ Marriage ☐ Typographical Error
☐ Divorce ☐ Court Action

Additional Instructions:

Please attach a copy of your proof of identify. Valid proof of identity may be one of the following documents:

Driver's license Passport marriage license signed SSN card
Birth certificate notarized court document

The Office of the Registrar will not accept documents that have expired and reserves the right to request additional documentation prior to completing a name change request.

- ***Return completed form along with documentation to the Registrar's Office.***

For Office Use Only

Date changed: _____ Initials: _____
Date notified depts.: _____ Initials: _____