UNIVERSITY OF ST. AUGUSTINE
FOR HEALTH SCIENCES

NAME CHANGE REQUEST

Please fill out the following information and forward to the registrar with one of the required documents.

Full name **(while in school)**

Full new name

Current street address

City State Zip

( ) ( )

Home Phone Work or Cell Phone

Please check which one of the following documents you are including with your name change request. Please be sure that the documentation reflects the new name.

- o Social Security Card
- o Driver's License
- o Passport
- o Military ID
- o Divorce Decree
- o Professional License

Please fax or mail your request and documentation copy to:

Attn: Registrar
University of St. Augustine for Health Sciences
1 University Blvd.
St. Augustine, FL 32086
Fax: (904) 823-3445

Signature required Date

For Registrar Office Use

Registrar Signature Date