



INDIVIDUAL NAME CHANGE APPLICATION

DO NOT WRITE IN THIS BOX -FOR DSHS USE ONLY		
BUDGET/FUND: <u>ZZ112-178</u> REMIT # _____ REMIT DATE: _____ AMT RECVD: _____	<div style="border: 1px solid black; width: 100px; height: 100px; margin: 0 auto;"></div> <p>2 inch by 2 inch Color Photo</p>	RCVD DATE: _____ INIT: _____ APRV DATE: _____ INIT: _____ FILE # _____ APP # _____

Asbestos License Type	
WORKER	<input type="checkbox"/>
SUPERVISOR	<input type="checkbox"/>
AIR MONITORING TECH	<input type="checkbox"/>
INSPECTOR	<input type="checkbox"/>
PROJECT MANAGER	<input type="checkbox"/>
INDIVIDUAL CONSULTANT	<input type="checkbox"/>
MANAGEMENT PLANNER	<input type="checkbox"/>
O & M SUPERVISOR	<input type="checkbox"/>
AMT PROJECT MONITOR	<input type="checkbox"/>

License Information	
LICENSE NUMBER	
LICENSE EXP DATE	

Must submit proof of official name change for your application to be processed. The fee is \$20.

PREVIOUS NAME USED				
LAST NAME	FIRST NAME	MIDDLE NAME		
NEW NAME USED				
LAST NAME	FIRST NAME	MIDDLE NAME		
REASON FOR NAME CHANGE	PHONE #	EMAIL ADDRESS		
HOME ADDRESS		CITY	STATE	ZIP CODE
MAILING ADDRESS		CITY	STATE	ZIP CODE

CERTIFICATION: I certify that I have read and understand the applicable rules and agree to comply with them. I understand that it is a violation of DSHS rules and the Texas Penal Code §37.10 to submit any false or fraudulent information or documents in order to obtain a license. I also understand that disclosure of my social security number is mandatory under Family Code Chapter 231.302(C)(1), and will be used for identification and reporting purposes required by law. All information I have provided on this application is true, correct, and complete to the best of my knowledge.

DATE	SIGNATURE

Mailing address

Department of State Health Services
Cash Receipts Branch – MC 2003
PO Box 149347
Austin, TX 78714-9347