Professional and Vocational Licensing Division
FAX: (808) 586-3031

Deliver to: 335 Merchant Street, Suite 301, Honolulu, HI 96813
Mail to: P.O. Box 3469, Honolulu, HI 96801
Email to: pvl@dcca.hawaii.gov

ADDRESS / NAME CHANGE / DUPLICATE LICENSE REQUEST

(FOR HEALTH CARE PROFESSIONALS)

Access this form via website at: **cca.hawaii.gov/pvl**

This form is to be used only by licensees regulated by the Professional and Vocational Licensing Division

1. OLD Name or OLD Address

Please complete the request form using the on-line fillable form, OR by printing legibly in dark ink.

LAST Name _____ FIRST Name _____ Middle Name or Initial _____

Social Security No. _____ Profession _____ License No. or Application applied for _____

Entity Name _____

Personal E-mail Address _____ Phone No.: (____) _____

OLD Address _____ City _____ State _____ Zip Code _____

This address is my: ◯ RESIDENCE HOME ◯ MAILING ◯ **PERSONAL** EMAIL

2. NEW Name or NEW Address

NOTE: You may NOT use this form to request a change of BUSINESS name. A copy of any of the following documentation must accompany a name change request: marriage license, divorce decree, court order, etc. **DO NOT SEND ORIGINALS.**

LAST Name _____ FIRST Name _____ Middle Name or Initial _____

Entity Name _____

Personal E-mail Address _____ Phone No.: (____) _____

NEW Address _____ City _____ State _____ Zip Code _____

This address is my: ◯ RESIDENCE HOME ◯ MAILING ◯ **PERSONAL** EMAIL

3. Duplicate Wallet License Request (optional) - Accepted by mail or delivery ONLY

If you want a duplicate wallet license printed with your new name and/or address, check the reason you need a duplicate, sign and date your request, and attach a check or money order for **$10.00** made payable to: COMMERCE AND CONSUMER AFFAIRS. (check must be in U.S. dollars and be from a U.S. financial institution.) A new license will be requested for you and should arrive in your mailbox within two weeks. **You are not required to obtain a new license when you change your name or address. This is strictly your choice.** During your next renewal, the renewal notice and license will automatically print with your new name and/or address.

(RETURN BOTH PAGES - SIGNATURE REQUIRED ON PAGE 2)

Name of Applicant: _____ Date: _____

Attach fee of **$10.00** and **CHECK ONE REASON BELOW:**

- ☐ Name Change
- ☐ Destroyed/Lost
- ☐ Address Change
- ☐ Stolen (Fee waived) - **A COPY OF POLICE REPORT MUST BE SUBMITTED ALONG WITH THIS REQUEST.**
- ☐ Printed w/the wrong Name/Address
- ☐ Other, explain: _____

4. Duplicate Wall Certificate Request (optional) - Accepted by mail or delivery ONLY

If you want a duplicate wall certificate, check the reason you need a duplicate, sign and date your request, and attach a check or money order for **$10.00** made payable to: COMMERCE AND CONSUMER AFFAIRS. (check must be in U.S. dollars and be from a U.S. financial institution.) A new wall certificate will be requested for you and should arrive in your mailbox within two weeks.

Attach fee of **$10.00** and **CHECK ONE REASON BELOW**:

- ☐ Name Change
- ☐ Destroyed/Lost
- ☐ Printed w/the wrong Name
- ☐ Other, explain: _____

The following license types do NOT have wall certificates:

MEDICAL (RESIDENCY, EMTB/EMTP & TEMPORARY)

NSG (RN/LPN ENDORSEMENT, APRN & RX)

5. Affidavit

I hereby certify that the information provided on this form is true and correct. I understand that any misrepresentation is grounds for refusal to grant or subsequent revocation of license and is a misdemeanor (Section 710-1017, Section 436B-19, HRS).

_____ _____

Signature Date

6. Deliver, fax, mail, or email this completed form to the ADDRESS ON PAGE 1. If payment is required for your request, attach payment.

Print Form

This material can be made available for individuals with special needs. Please call the Licensing Branch Manager at (808) 586-3000 to submit your request.