Professional and Vocational Licensing Division	**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 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. 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 _____

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.

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Print Form