



**CHANGE OF
INFORMATION or
REQUEST FOR A
DUPLICATIVE LICENSE**

NEVADA STATE HEALTH DIVISION
Bureau of Health Care Quality and Compliance
727 Fairview Drive, Suite E
Carson City, Nevada 89701
Phone: (775) 684-1030 Fax: (775) 684-1073

Please complete this form and submit to our office (mail, fax or email). Please complete this form electronically or print with black or blue ink or type in the information.

Check one of the following:

- I am a licensed Professional (Dietitian or Music Therapist) in Nevada.
- I am an Applicant, not yet licensed in Nevada.

Check one of the following:

- I am changing my physical address.
- I am changing my mailing address.
- I am changing my email.
- I am changing my name.
- I would like a reprint of my license (name changed on my license).*
- I am requesting a duplicative license.*

*There is a \$20 fee for the issuance of a duplicative license or changing the name on your license (reprint).

*If requesting a duplicative license or a reprint of your license you cannot use the email or fax option to submit this form. Mail this form with the \$20 fee via personal check, cashier's check or money order made payable to the order of: Nevada State Treasurer.

Section 1: Complete for all changes and request for a duplicative license – Enter information currently on file

Last Name: _____ Former/Maiden Name: _____

First Name: _____ Middle Initial: _____

Nevada License # (If applicable): _____ Profession: _____

Date of Birth: ____/____/____

Section 2: Complete for change of address, email or phone – Enter new information (leave blank any areas not being changed)

New Physical Address: _____ Apt/Suite#: _____

City: _____ County: _____ State: _____ Zip: _____

Phone #: _____ Email Address: _____

New Mailing Address: _____ Apt/Suite#: _____

City: _____ County: _____ State: _____ Zip: _____

Section 3: Complete for change of name – Enter New Name:

Last Name (updated to): _____

First Name: _____ Middle Initial: _____

Reason for change* *(check one and submit with your form):*

- Marriage (Must have a copy of your Marriage License/Civil Union Certificate)
- Divorce (Must have a copy of Divorce Decree)
- Other (Must have a copy of a Probate Court Order or Government Issued ID)

I understand that my application may be denied or my license suspended or revoked, as applicable, for failing to notify the Bureau of a change to the information contained in my application within 15 days after the change.

Signed: _____ Date: _____

Submit to:

Nevada State Health Division
Bureau of Health Care Quality and Compliance
Dietitian Licensing Unit
727 Fairview Drive, Suite E
Carson City, NV 89701
Fax: (775) 684-1073
E-mail: individuallicensing@health.nv.gov