DEPARTMENT OF HEALTH

Change of Information

SPEECH-LANGUAGE PATHOLOGISTS AND AUDIOLOGISTS

Minnesota statute requires licensees to notify the Minnesota Department of Health (MDH) **within thirty days** when there is a change of name, employment, or address. A name change request must be submitted with a copy of a marriage certificate or court order.

Minnesota Statute 148.519, Subd. 3 (https://www.revisor.mn.gov/statutes/cite/148.519)

Complete the section(s) that require a change of information. Information marked with an asterisk (*) is required to process changes of information. Current or previous information must be provided for any information that is being updated. For example, you must include both the previous and new home address if that is the information you need to update.

Change of Name

Provide a copy of a marriage certificate or court order with your name change request. Information marked with an asterisk (*) is required to process changes of information.

*Current Legal Name on License: _____

*Licensee's New Legal Name: _____

*MDH License Number: _____

*Effective Date of Change: _____

Change of Contact Information

Please designate the address in which you will receive correspondence from MDH regarding your license. Critical information about license renewals will be sent to your email address. Provide the full street address including city, state & zip code. Information marked with an asterisk (*) is required to process changes of information.

☐ Home ☐ Employer ☐ Other

*Licensee Name: _____

*MDH License Number: _____

*Effective Date of Changes: _____

Previous Home Address: _____

New Home Address: _____

Previous Mailing Address: _____

New Mailing Address: _____

Phone Number: _____

Previous Email Address: _____

New Email Address: _____

Change of Employment

Provide the full business street address including city, state & zip code. Please attach additional pages if you have more than one employment change to report.

*Licensee Name: _____

*MDH License Number: _____

Previous Employer Name: _____

Previous Employment Address: _____

Previous Employment End-Date (mm/dd/yyyy): _____

New Employer Name: _____

New Employment Address: _____

New Employment Phone Number: _____

New Employment Effective Date (mm/dd/yyyy): _____

Licensee Signature

MDH will accept electronic signatures.

I acknowledge the information provided on this form is correct and authorize MDH to accept the requested changes.

*Licensee Name (print): _____

*Licensee Signature: _____

*Date (mm/dd/yyyy): _____

Submitting the Completed Document

Return the completed *Change of Information* form to MDH by mail or email health.slpa@state.mn.us.

Health Occupations Program
Speech-Language Pathology/Audiology Licensing
PO Box 64882
St. Paul, MN 55164-0882
651-201-4200
Health.slpa@state.mn.us
https://www.health.state.mn.us/facilities/providers/slpa/index.html

10/21/2022

To obtain this information in a different format, call: 651-201-4200.