IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF MEDICAID
BUREAU OF FACILITY STANDARDS
3232 Elder Street
PO Box 83720
Boise, ID 83720-0036

Phone: 208-334-6620
Fax: 208-334-6629

AFFIDAVIT FOR CHANGE OF NAME
NURSING ASSISTANT REGISTRY

Please complet, have notarized, and return to this office as soon as possible, so that a change of name can be made on the Registry. We cannot change the Registry without legal notarized evidence of your name change.

STATE OF AL }

} **SOCIAL SECURITY NUMBER** _____

COUNTY OF _____ }

I, _____ being duly sworn, testity
(Please enter Present Name)

that on _____ day of _____ , _____ , my name was changed for the reason checked below:

- ◯ Marriage to _____
- ◯ Divorce from _____
- ◯ Other reasons (Please explain) _____

and that prior to this change my name was _____

Signature _____

Address _____

City _____ State _____ Zip Code _____

On this _____ day of _____, in the year of _____, before me _____, a notaary public, personally appeared _____, known or identified to me, to be the person whose name is subscribed with instrument, and acknowledge to me that he/she executed the same.
WITNESS my hand and official seal.

_____

Notary Public Commission Expires