



REQUEST FOR NAME CHANGE IN REGISTER

College of Complementary Health Professionals of British Columbia

REQUEST TO CHANGE NAME IN REGISTER

If you have legally changed your name and you would like to change your practice name registered with the College, please complete and submit this form and supporting documents by mail to:

College of Complementary Health Professionals of BC of British Columbia (CCHPBC)
900 - 200 Granville St, Vancouver, BC, V6C 1S4, Canada

PERSONAL INFORMATION

Legal Last Name	Legal First Name	Legal Middle Name (if any)
Previous Last Name	Previous First Name	Previous Middle Name (if any)
TCMA Registration Number	Date of Birth (MM/DD/YYYY)	

SUPPORTING DOCUMENTS

As proof of my current legal name, I have attached NOTARIZED COPIES of the following (select one):

- ☐ TWO Canadian Government issued Photo Identifications such as Driver's Licence, BCID, BC Services Card, Passport, Citizenship Card, Permanent Resident Card
- ☐ ONE Canadian Government issued Photo Identifications such as Driver's Licence, BCID, BC Services Card, Passport, Citizenship Card, Permanent Resident Card; and ONE Canadian Government issued Marriage Certificate with my spouse's and my full legal name
- ☐ ONE Canadian Government issued Certificate of Change of Name with my previous and current full legal name

DECLARATION

I declare that all the information and statements made in or submitted with this request are true, complete and correct, and I make this declaration conscientiously believing it to be true and knowing that it is of the same force and effect as if made under oath. I also understand that misstatements or omissions of material facts may be cause for denial of this request, or for suspension or revocation of registration.

Signature of Applicant:	Date:
-------------------------	-------

*** Keep copies of all application documents for your file. NO document will be returned to you.**