ALLIANT | GMCF
MAKING HEALTH CARE BETTER

STATE OF GEORGIA
ASSISTED LIVING COMMUNITY CMA REGISTRY
REGISTERED NURSE/PHARMACIST/PHYSICIAN NAME CHANGE FORM

Please fill out this form completely. Incomplete forms will not be processed. Please check www.mmis.georgia.gov to verify name change. **Allow 14 business days for processing.**

Instructions:

1. Provide complete information in the spaces provided.
2. Sign and date the form at the bottom.
3. Provide a copy of the current license from Georgia State Board. **Name must be changed with the Georgia State Board before submitting this form.**
4. Fax this form and copy of current Georgia licensure information to 678-527-3034.

Previous Name:

Name
(Last)_____First)_____(Middle)_____

New Name:

Name
(Last)_____First)_____(Middle)_____

Georgia State Board License #:_____

Georgia State Board Expiration Date:_____

I certify that the above information is true and complete.

_____ _____

SIGNATURE OF RN/PHARMACIST/PHYSICIAN DATE