**STATE OF GEORGIA**
**CERTIFIED MEDICATION AIDE REGISTRY**
**CMA INSTRUCTOR NAME CHANGE FORM**

**Alliant Health Solutions**
**Georgia Medication Aide Registry**
**P.O. Box 105753**
**Atlanta, GA 30348**

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. Mail this form and copy of current Georgia licensure information to the address above.

**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 DATE