ALLIANT HEALTH SOLUTIONS

STATE OF GEORGIA
ASSISTED LIVING COMMUNITY CMA REGISTRY
REGISTERED NURSE/PHARMACIST/PHYSICIAN 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/PHYSICIAN DATE