



STATE OF GEORGIA
ASSISTED LIVING COMMUNITY
MEDICATION AIDE REGISTRY
REQUEST A CHANGE OF NAME OR ADDRESS

Georgia Medical Care Foundation
Georgia Medication Aide Registry
P.O. Box 105753
Atlanta, GA 30348

If your name has changed, please fill out this form completely. Incomplete forms will not be processed. All forms can be printed via the website (www.mmis.georgia.gov). Questions should be directed to the Georgia Medication Aide Registry at (678) 527-3010 or (800) 414-4358.

Instructions: (please type or write legibly so your request may be processed):

- 1. Provide complete information in the spaces provided.
2. Sign and date the form at the bottom.
3. Provide a copy of either your marriage/divorce decree, social security card or a court document that verifies your name change.
4. Provide copy of social security card to correct the spelling of your name on the registry.
5. Mail this form and a copy of your legal document for name change to the address listed below.

Certification Number # \_\_\_\_\_

or

Social Security Number # \_\_\_\_\_

Date of Birth \_\_\_\_\_

Name Change- Print

Previous Name:

Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_

New Name:

Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_

Address Change- Print

Old Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_ County \_\_\_\_\_

New Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_ County \_\_\_\_\_

I certify that the above information is true and complete.

PRINT NAME

SIGNATURE OF MEDICATION AIDE

DATE

Please allow 14 business days for processing.
Mail form to address listed at top of page.