OFFICE OF THE REGISTRAR
NAME CHANGE REQUEST

Please complete the following information and supporting documents to the Office of the Registrar, leaving requested information blank results in processing delays.

BCM ID: _____

STUDENT INFORMATION *(Please Print)*		
NAME *(As it **CURRENTLY** appears on record)*		
TELEPHONE NUMBER	**EMAIL ADDRESS**	**GRADUATION DATE**
ACADEMIC PROGRAM: ☐ **MEDICAL** ☐ **HEALTH PROFESSIONS** ☐ **GRADUATE SCHOOL** ☐ **TROPICAL MEDICINE**		

LEGAL NAME AS IT SHOULD APPEAR ON OFFICIAL ACADEMIC RECORD

☐ **LEGAL NAME CHANGE**

☐ **NAME CORRECTION DUE TO TYPO, MISSPELLING OR EXPAND FULL LEGAL NAME.**

PLEASE PRINT NAME EXACTLY AS IT SHOULD APPEAR ON OFFICIAL ACADEMIC RECORD

FIRST	**MIDDLE**	**LAST**

CERTIFIED DOCUMENTATION REQUIRED: *Please attach **ONE** of the following birth certificate, passport, marriage license, divorce or other court decree, or adoption documentation.* ***NOTE:*** Social security card & driver's license are acceptable ***ONLY IF*** accompanied together.

THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE

SIGNATURE: _____ **DATE:** _____

*(Written Signature Required **NO** Electronic Signatures Will Be Accepted)*

SUBMIT COMPLETED REQUEST *AND* SUPPORTING DOCUMENTATION TO:

Baylor College of Medicine, Office of the Registrar
One Baylor Plaza | Mail Stop: BCM365 | Houston, TX 77030
Phone: (713) 798-7766 | Fax: (713) 798-1518 | Email: registrar@bcm.edu

FOR OFFICE USE ONLY

PROCESSED INITIALS: _____ ***PROCESSED DATE:*** _____