UNIVERSITY OF ST. AUGUSTINE
FOR HEALTH SCIENCES

NAME CHANGE REQUEST

Please fill out the following information and forward the completed form with one of the required documents listed below to the Registrar's office at registrar@usa.edu**. Please note:** Typed in signatures are not accepted. Please either provide your real signature or utilize the Adobe PDF digital signature with watermark.

Student ID#: _____

Full name (while in school): _____
First Name Middle Name Last Name

Full new name: _____
First Name Middle Name Last Name

Current Address: _____

City: _____ **State:** _____ **Zip:** _____

Cell Phone: _____ **Work Phone:** _____

Please check which of the following documents you are including with your name change request. Please be sure that the document reflects the new name.

- ○ Social Security Card
- ○ Driver's License
- ○ Passport
- ○ Military ID
- ○ Divorce Decree
- ○ Professional License

Please scan and email your request and documentation to registrar@usa.edu

_____ _____
Signature **Date**

_____ _____
Registrar Signature **Date**

Registrar Office Use Only:

☐ Bursar ☐ Financial Aid ☐ Clin Ed ☐Student File ☐ Advisor ☐ IT for email address update

Revised: 10-2021