



GOVERNMENT OF THE VIRGIN ISLANDS OF THE UNITED STATES
DEPARTMENT OF HEALTH
OFFICE OF LICENSURE BOARDS & REGULATORY SERVICES

4006 Estate Diamond, Suite 104, Christiansted, St. Croix, VI 00820-5351 • Phone No.: (340) 643-8992

Provider Legal Name Change Request

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Submit to request an official update to a provider's name of record for legal and administrative purposes.

1. Provider Information

Current Legal Name (as on file)

Requested New Legal Name

Provider ID / NPI Number

Date of Birth (MM/DD/YYYY)

Department / Practice

Job Title / Credentials

Contact Phone

Contact Email

2. Reason for Name Change (select one)

☐ Marriage

☐ Divorce

☐ Court-ordered legal name change

☐ Correction of a clerical error

☐ Personal (no reason required)

☐ Other (specify below)

If Other, please specify

3. Effective Date & Supporting Documentation

Requested Effective Date (MM/DD/YYYY)

Documentation attached (select all that apply):

☐ Marriage certificate

☐ Divorce decree

☐ Court order

☐ Updated Social Security card

☐ Updated driver's license / state ID

☐ Other supporting document



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Continued — records update, certification, and administrative approval.

4. Boards, Licenses & Records to Be Updated

Select every board / license / process affected by this name change:

- | | |
|---|---|
| ☐ VI Allied Health Professionals Clearance | ☐ VI Certificate of Need |
| ☐ VI Board of Chiropractic Examiners | ☐ VI Board of Dental Examiners |
| ☐ VI Board of Medical Examiners | ☐ VI Board of Optometric Examiners |
| ☐ VI Board of Pharmacy | ☐ VI Board of Physical Therapy |
| ☐ VI Board of Psychology | ☐ VI Board of Podiatry Examiners |
| ☐ VI Board of Veterinary Medicine | ☐ Other (specify below) |

If Other, please specify

5. Provider Certification

I certify that the information provided above is true and accurate, and that supporting documentation has been provided to substantiate this legal name change request.

Provider Signature

Date

6. Administrative Review (Office of Licensure Boards & Regulatory Services Use Only)

Reviewer Name

Review Date

- | | | |
|-----------------------------------|---------------------------------|---|
| ☐ Approved | ☐ Denied | ☐ Pending additional documentation |
|-----------------------------------|---------------------------------|---|

Comments

Reviewer Signature

Date