NORTH CAROLINA BOARD
of LICENSED CLINICAL
MENTAL HEALTH
COUNSELORS

PHONE: 844-622-3572
FAX: 336-217-9450
WEB: ncblcmhc.org
EMAIL: LCMHCinfo@ncblcmhc.org

# Name Change Form

You must Mail name changes, **faxed copies are not acceptable.**

Mail this form to: NCBLCMHC
PO Box 77819
Greensboro NC 27417

Please be sure to attach copies of all legal documentation, such as marriage certificate, divorce papers, or other court documents in order for the Board to process your name change request. Changes must be submitted with 60 days of change.

LCMHC#_____ **OR** SS #_____ - _____ - _____

Previous Name _____

New Name _____

Documentation Enclosed: ___ Marriage Certificate ___ Divorce Decree ___ Other

This form must be signed by the licensee/applicant in order to be processed.

_____ _____
Signature Date

**If you would like to request a duplicate license with the new name, please complete the Request for Duplicate License Form below.**

# Request for Duplicate License Form

Duplicate licenses may be obtained by sending this form with **$15** payment (check, money order or credit card info) to the address above.

*If your name has changed, the Board does not require you to obtain a license with your new name. However, if you wish to obtain one, mail this form along with the Name Change form and payment to the address listed above.*

Name _____

Address _____

City/State/ZIP _____

I am paying by: ___ check (#_____) ☐ credit card

Amount paid: $_____ Amount to be charged: $_____

CC Type: ___ VISA ___ MasterCard Expiration Date: _____

CC #: _____

_____
Cardholder's Signature *(required)*