# CHANGE OF NAME AND CONTACT INFORMATION REQUEST FORM

**ACOM – Office of the Registrar**
**445 Health Sciences Blvd., Dothan, AL 36303**
**Phone: 334-699-2266 ● Fax: 334-699-2268**
**Email: registrar@acom.edu**

Southeast HEALTH
ALABAMA COLLEGE OF OSTEOPATHIC MEDICINE

**PERSONAL INFORMATION:** Please Print

Last Name: _____ First Name: _____ Middle: _____

Student ID No.: _____ Class of: _____ Class Level: _____

DOB: _____Email: _____ Phone: _____

Address: _____

**SECTION I – CURRENT MAILING:** Please complete this section if your current mailing address has changed

Street Address: _____

City: _____ State: _____ Zip Code: _____

**SECTION II – PERMANENT MAILING:** Please complete this section if your permanent mailing address has changed

Street Address: _____

City: _____ State: _____ Zip Code: _____

**SECTION III – NAME:** Please complete this section if your name has changed

Additional documentation is required – ie. Marriage certificate, court order, passport, photo ID, etc. Name needs to reflect as reported on Social Security Card. Expired documentations are considered invalid.

Former Full Name: _____

Current Full Name: _____

**REQUEST VERIFICATION:** Please Sign

Student Signature: _____Date: _____