MEDICAL COUNCIL OF CANADA
LE CONSEIL MÉDICAL DU CANADA

ADDRESS 1021 Thomas Spratt Place
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CONTACT MCC.CA
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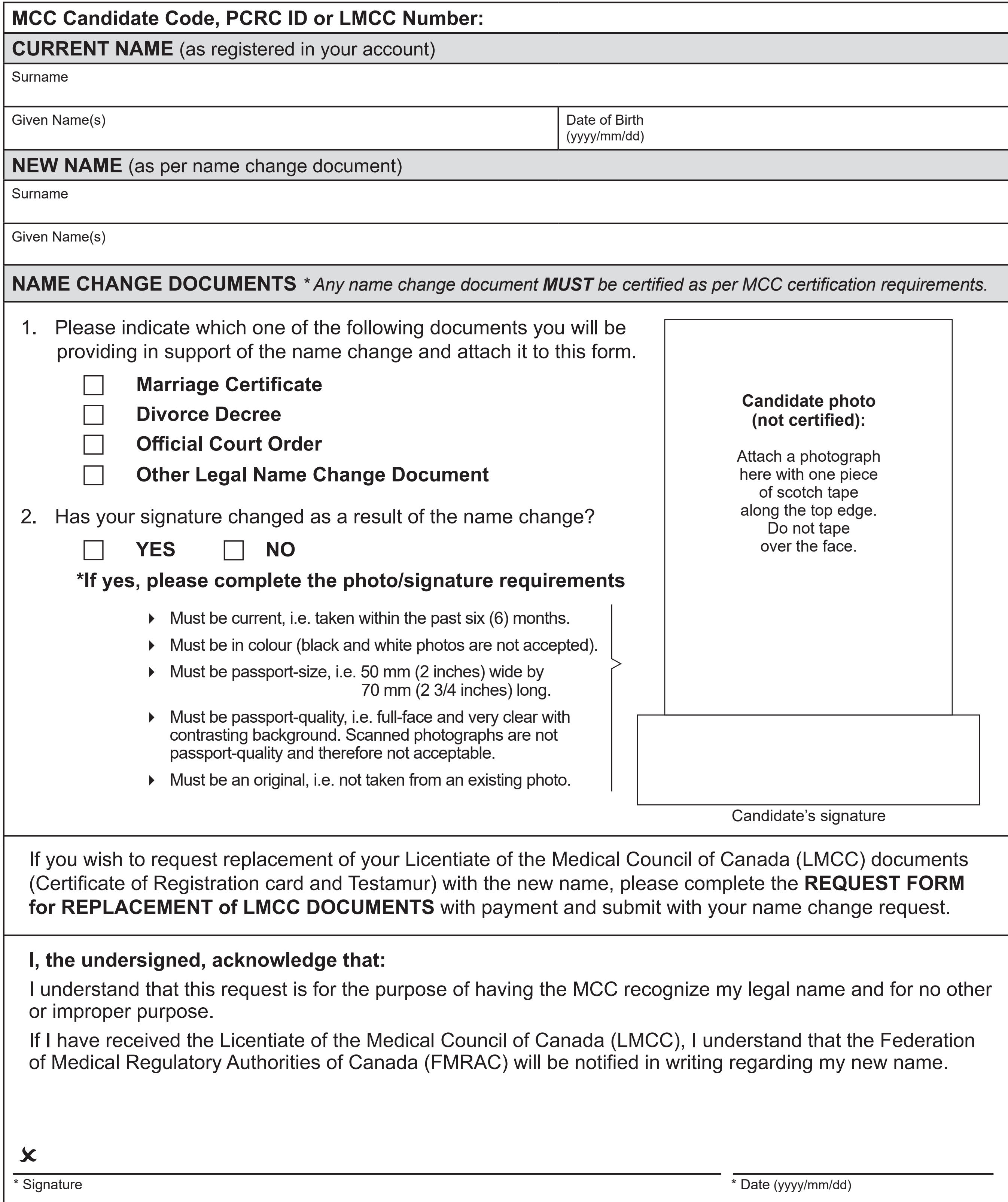
NAME CHANGE REQUEST FORM



MCC Candidate Code, PCRC ID or LMCC Number:

CURRENT NAME (as registered in your account)

Surname

Given Name(s) | Date of Birth (yyyy/mm/dd)

NEW NAME (as per name change document)

Surname

Given Name(s)

NAME CHANGE DOCUMENTS ** Any name change document* ***MUST*** *be certified as per MCC certification requirements.*

1. Please indicate which one of the following documents you will be providing in support of the name change and attach it to this form.
   - ☐ **Marriage Certificate**
   - ☐ **Divorce Decree**
   - ☐ **Official Court Order**
   - ☐ **Other Legal Name Change Document**
2. Has your signature changed as a result of the name change?

   ☐ **YES** ☐ **NO**

   ***If yes, please complete the photo/signature requirements**

   - Must be current, i.e. taken within the past six (6) months.
   - Must be in colour (black and white photos are not accepted).
   - Must be passport-size, i.e. 50 mm (2 inches) wide by 70 mm (2 3/4 inches) long.
   - Must be passport-quality, i.e. full-face and very clear with contrasting background. Scanned photographs are not passport-quality and therefore not acceptable.
   - Must be an original, i.e. not taken from an existing photo.

Candidate photo (not certified):

Attach a photograph here with one piece of scotch tape along the top edge. Do not tape over the face.

Candidate's signature

If you wish to request replacement of your Licentiate of the Medical Council of Canada (LMCC) documents (Certificate of Registration card and Testamur) with the new name, please complete the **REQUEST FORM for REPLACEMENT of LMCC DOCUMENTS** with payment and submit with your name change request.

I, the undersigned, acknowledge that:

I understand that this request is for the purpose of having the MCC recognize my legal name and for no other or improper purpose.

If I have received the Licentiate of the Medical Council of Canada (LMCC), I understand that the Federation of Medical Regulatory Authorities of Canada (FMRAC) will be notified in writing regarding my new name.

✗

* Signature | * Date (yyyy/mm/dd)

* Required