

### NAME CHANGE REQUEST FORM

<b>MCC Candidate Code, PCRC ID or LMCC Number:</b>	
<b>CURRENT NAME</b> (as registered in your account)	
Surname	
Given Name(s)	Date of Birth (yyyy/mm/dd)
<b>NEW NAME</b> (as per name change document)	
Surname	
Given Name(s)	
<b>NAME CHANGE DOCUMENTS</b> * Any name change document <b>MUST</b> be certified as per MCC certification requirements.	
<p>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.</p> <p><input type="checkbox"/> <b>Marriage Certificate</b></p> <p><input type="checkbox"/> <b>Divorce Decree</b></p> <p><input type="checkbox"/> <b>Official Court Order</b></p> <p><input type="checkbox"/> <b>Other Legal Name Change Document</b></p> <p>2. Has your signature changed as a result of the name change?</p> <p><input type="checkbox"/> <b>YES</b>    <input type="checkbox"/> <b>NO</b></p> <p><b>*If yes, please complete the photo/signature requirements</b></p> <ul style="list-style-type: none"> <li>▶ Must be current, i.e. taken within the past six (6) months.</li> <li>▶ Must be in colour (black and white photos are not accepted).</li> <li>▶ Must be passport-size, i.e. 50 mm (2 inches) wide by 70 mm (2 3/4 inches) long.</li> <li>▶ Must be passport-quality, i.e. full-face and very clear with contrasting background. Scanned photographs are not passport-quality and therefore not acceptable.</li> <li>▶ Must be an original, i.e. not taken from an existing photo.</li> </ul>	<div style="border: 1px solid black; padding: 10px; margin-bottom: 10px;"> <p><b>Candidate photo (not certified):</b></p> <p>Attach a photograph here with one piece of clear tape along the top edge. Do not tape over the face.</p> </div> <div style="border: 1px solid black; width: 100%; height: 30px; margin-bottom: 10px;"></div> <p>Candidate's signature</p>
<p>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 <b>REQUEST FORM FOR REPLACEMENT OF LMCC DOCUMENTS</b> and submit with your name change request.</p>	
<p><b>I, the undersigned, acknowledge that:</b></p> <p>I understand that this request is for the purpose of having the MCC recognize my legal name and for no other or improper purpose.</p> <p>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.</p>	
<p><b>x</b></p> <p>* Signature</p>	<p>* Date (yyyy/mm/dd)</p>

\* Required