

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	
<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"/> Marriage Certificate</p> <p><input type="checkbox"/> Divorce Decree</p> <p><input type="checkbox"/> Official Court Order</p> <p><input type="checkbox"/> Other Legal Name Change Document</p> <p>Please do not send your original documents, <i>only copies</i>, as your original documents will not be returned to you.</p> <p>2. Has your signature changed as a result of the name change?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>*If yes, please complete the photo/signature requirements</p> <ul style="list-style-type: none"> ▶ 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. 	<div style="border: 1px solid black; padding: 10px; margin: 10px auto; width: 80%;"> <p>Candidate photo (not certified):</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: 80%; margin: 10px auto; height: 40px;"></div> <p style="text-align: center;">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 REQUEST FORM FOR REPLACEMENT OF LMCC DOCUMENTS and submit with your name change request.</p>	
<p>I, the undersigned, acknowledge that:</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>X</p> <p>* Signature</p>	<p>* Date (yyyy/mm/dd)</p>

* Required