



MEDICAL BOARD OF WESTERN AUSTRALIA

ABN: 25 271 541 367

APPLICATION FOR CHANGE OF NAME

I,	
(Full name in block letters - underline Surname)	
Registration Number:	
of	

make the following notification to the Medical Board of Western Australia:

<p>Current name on the Medical Board Register _____</p> <p>to be changed to _____</p> <p><input type="checkbox"/> I attach a certified[†] copy of evidence of my change of name; and</p> <p><input type="checkbox"/> Enclose the fee of \$30.00.</p>
<p>_____</p> <p style="text-align: center;"><i>Signature of Applicant</i></p>
<p>this _____ day of _____ 20_____</p>
<p>_____</p> <p style="text-align: center;"><i>Signature of Witness</i></p>

Certified Documents[†]

Documents can only be accepted if certified by a person described in section 12 (6) (a) – (c) of the *Oaths, Affidavits and Statutory Declarations Act 2005* or an authorised representative of the Registrar of the Medical Board of Western Australia. For further information, please refer to the Board’s website – Registration Information.

PAYMENT BY CREDIT CARD (VISA OR MASTERCARD)			
Name on Card			
Card number	- - -		
	<input type="checkbox"/> Visa	<input type="checkbox"/> MasterCard	Expiry _____ / _____
Signature of Cardholder:			