



**STATE OF GEORGIA
 MEDICATION AIDE REGISTRY
 REQUEST A CHANGE OF NAME OR ADDRESS**

**Alliant Health Solutions
 Georgia Medication Aide Registry
 P.O. Box 105753
 Atlanta, GA 30348**

If your name has changed, please fill out this form completely. Incomplete forms will not be processed. All forms can be printed via the website (www.mmis.georgia.gov). If there is a change of address, it is the sole responsibility of the CMA to report this change. The CMA has 10 working days to report the change so that the registry will be updated appropriately. Questions should be directed to the Georgia Medication Aide Registry at (678) 527-3010 or (800) 414-4358.

Instructions: (please type or write legibly so your request may be processed):

1. Provide complete information in the spaces provided.
2. Sign and date the form at the bottom.
3. Provide a copy of either your marriage/divorce decree, social security card or a court document that verifies your name change.
4. Provide copy of social security card to correct the spelling of your name on the registry.
5. Mail this form **and** a **copy** of your legal document for name change to the address listed below.

Certification Number # _____
 Last 4 Digits of SSN # _____

Date of Birth _____ Email: _____

Name Change- Print

Previous Name:

Name (Last) _____ (First) _____ (Middle) _____

New Name:

Name (Last) _____ (First) _____ (Middle) _____

Address Change- Print

Old Address _____

City _____ State _____ Zip code _____ County _____

New Address _____

City _____ State _____ Zip code _____ County _____

I certify that the above information is true and complete.

PRINT NAME

SIGNATURE OF MEDICATION AIDE _____
DATE

**Please allow 14 business days for processing.
 Mail form to address listed at top of page.**