

AUTHORIZED PHYSICIST REPORT OF NAME OR ADDRESS CHANGE

Pursuant to the California Code of Civil Procedure Section 1275, name change requests must be accompanied by a copy of a certified superior court order allowing the name change, a government issued picture ID, such as a driver's license, military ID, or passport.

MQA Number (Mammography Physicist): _____

TCP Number (Therapy Calibration Physicist): _____

TSP Number (Therapy Survey Physicist): _____

PREVIOUS NAME AND ADDRESS:

Name _____

Address _____

City, State, Zip Code _____

CURRENT NAME AND ADDRESS:

The information you provide on this form may be made public under the California Public Records Act; please provide a P.O. Box number or other alternate address if you do not wish to have your home address made public.

Name _____

Mailing Address (Number and Street or P.O. Box Number)

City, State, Zip Code _____

Daytime Telephone _____

E-mail Address _____

Signature _____ Date _____

E-MAIL COMPLETED FORM TO: RHBRMT@cdph.ca.gov

For information or access to your records and submittal of this application, contact the Chief of the Registration Unit at the California Department of Public Health, Radiologic Health Branch, at RHBRMT@cdph.ca.gov