College of Health Professions Office of the Registrar

Personal Information Change Request Form

Student Name: _____

Student ID Number: _____

Date of Birth: _____

Program: _____

Legal Name Change

Legal Name Change to: _____

Date of Name Change: _____

Address Change

Indicate address affected by change:

☐ Current Address

☐ Permanent Address

☐ Both

Please print the new address (apartment number if applicable) and contact number:

Street: _____

City: _____

State: _____

Zip: _____

Student Signature: _____

Date: _____

Return completed form by Mail, Fax, or Hand Delivery

MAIL: University of Arkansas for Medical Sciences, University Registrar Office, 4301 West Markham, Mail Slot 767, Little Rock, Arkansas 72205

FAX: 501-526-3220 – Attention Phyllis Lloyd

HAND DELIVER: University Registrar Office, Building 2 (near UAMS Bookstore), Room 101