ARKANSAS STATE BOARD OF PUBLIC ACCOUNTANCY
900 West Capitol, Suite 400, Little Rock, AR 72201
Phone (501) 682-1520 Fax (501) 682-5538
www.arkansas.gov/asbpa

WRITTEN NOTIFICATION OF **NAME CHANGE ONLY**

Complete ALL sections and return to the Board.

SSN: XXX **-** XX **-** _____ **CERTIFICATE #**_____
(Enter the last 4 digits of your SSN)

(The disclosure of your Social Security Number (SSN) is mandatory; it is solicited by the authority granted by 42 U.S.C. §666(a) (13) and A.C.A §17-1-104. It will be provided to the Arkansas Office of Child Support Enforcement for child support purposes. The failure to provide your SSN in this application will result in the denial of your application. Your SSN is not subject to public disclosure under the Freedom of Information Act; the disclosure of your SSN without your consent is a class B misdemeanor.)

The Board of Accountancy must be notified in writing within 30 days of name/address/employment change (Rule 9.1).

NAME ON FILE:

_____ _____ _____
LAST NAME **FIRST NAME** **MIDDLE NAME**

** CHANGE TO:

_____ _____ _____
LAST NAME **FIRST NAME** **MIDDLE NAME**

**** Name changes must be accompanied by a copy of legal documentation (i.e. marriage license, divorce decree, court order, etc.).**

IMPORTANT: Requests received without the official legal documentation will be returned and not processed.

I hereby certify that all statements and information including all supporting documents, are true, accurate, and correct to the best of my knowledge and belief. I am aware that my SSN will be used as described herein.

_____ _____
Signature *Date*