REQUEST FOR NAME CHANGE

A current or former student may request a name change by completing this form. Please note the following:

**Current students:** in order to receive Title IV funds (financial aid), your name on record with MCW must accurately reflect your current legal name on record with the Social Security Administration.

**Former students:** please update your name on record with Alumni Relations and Development via an email to alumni@mcw.edu.

**MCW employees:** please update your name on record with Human Resources via the Name Change Form available on the HR website.

**All students:** your current and former names will appear on the MSPE letter (medical students only) while only your current name will appear on transcripts.

Former Name: ____________________________________________

(Last name) (First name) (Middle name)

New Name: ______________________________________________

(Last name) (First name) (Middle name)

Program(s) of Study: ______________________________________

In order to complete a name change, at least one document from each category in the following list must be submitted with this form. The documents must include the current legal name.

<table>
<thead>
<tr>
<th>Category 1</th>
<th>Category 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Court Issued Documents</td>
<td>Driver's License</td>
</tr>
<tr>
<td>Divorce Decree</td>
<td>Government Issued Photo ID</td>
</tr>
<tr>
<td>Marriage Certificate</td>
<td>MCW ID</td>
</tr>
<tr>
<td>Social Security Card</td>
<td>U.S. Passport</td>
</tr>
</tbody>
</table>

**Current students only:**

Do you wish to also change your MCW email address and username?  Yes_______ No_______

If you check yes, MCW Information Services will contact you via MCW email or telephone.

Email: __________________________ Mobile Telephone Number: (______)___________________

Medical Students: Do you wish to order a new white coat name badge? Yes_______ No_______

The badge replacement fee is $20.00. Please attach exact cash or check made out to MCW with this form.

I verify the submitted documents are true and correct copies of the original documents.

Signature: __________________________________________ Date: ___________________

*Return this signed form to:* or *Return this form by emailing a PDF of the signed form to* acadreg@mcw.edu.

Medical College of Wisconsin
Office of the Registrar, M3200
8701 Watertown Plank Road
Milwaukee, Wisconsin 53226
(414) 955-8733

Rev. 8/11/2019