IOWA | Health and Human Services

AMANDA NAME CHANGE REQUEST FORM

This form is for individuals who hold EMS certification with the Iowa Bureau of Emergency Medical and Trauma Services.

Complete, sign and return this form to:
Iowa Department of Health and Human Services Bureau of Emergency Medical and Trauma Services
321 E 12th Street, Des Moines, IA 50319 or
Email:IowaHHSbemts@hhs.iowa.gov

Section I – Applicant Information

Previous Name:_____
First Middle Last

Current Street Address: _____

City: _____ State: _____ Zip Code: _____

License/Permit/Certification #: _____ Phone: _____

Email Address: _____

Section II – Identity Verification

Date of Birth:____/____/_____

Last 4 Digits of SSN: XXX – XX - _____ _____ _____ _____

New Name: _____
First Middle Last

Section III – Licensee Affirmation

My signature on this form affirms that the information I have provided on this request is true and accurate. I have truthfully represented my identity in this request for a name change in my licensure record.

_____ _____

Signature Date

January 2025