NURSING PROFILE CHANGE

PLEASE NOTE: ALL INFORMATION MUST BE COMPLETED

Date Submitted: ☐☐ - ☐☐ - ☐☐☐☐

Current Name on Health License: _____

Changing Name on Health License to: _____
(If changing name you must provide legal document of name change, ie. marriage certificate, divorce decree)

Date of Birth: ☐☐ - ☐☐ - ☐☐☐☐

Place of Birth: _____

Social Security Number: ☐☐☐ - ☐☐ - ☐☐☐☐

Rhode Island Department of Health License Number: _____

Home Address: _____

City: _____

State: _____ Zip Code: _____

Because of the NURSYS Compact if you are moving back into Rhode Island from another state you MUST provide proof of residency with this change form. i.e. Driver's license with RI address.

Home Telephone Number: _____ Home Fax Number: _____

Home Email Address: _____

Work Name: _____

Work Address: _____

City: _____

State: _____ Zip Code: _____

Work Telephone Number: _____ Work Fax Number: _____

Work Email Address: _____

Fax form with required documents (if applicable) to (401) 222-6683 or mail to:

Rhode Island Department of Health
Board of Nursing
Room 103
3 Capitol Hill
Providence, RI 02908-5097