SAINT FRANCIS MEDICAL CENTER
COLLEGE OF NURSING

DEMOGRAPHIC AND NAME CHANGE FORM

Please return the completed form to the College Support Representative areas in the lobby or Rm. 651.

Student name:_____ _____
(Print) (Signature)

Student ID #:_____ Date:_____

Address/Phone/E-mail change requested: **Effective date:**

Address:_____ _____

_____

_____
(City) (State) (Zip)

Phone: _____ _____

E-mail _____ _____

Name change requested: **Effective date:**

Change to:_____ _____
(Print)

Please submit to the Admissions Department, Room 627 or 628, documentation (i.e., marriage certificate, court papers, etc.) to support a legal name change.

Documentation received by:_____ Date:_____

SFMC CON office use only

Date form received by CSR:_____

Entered by:_____ SonisWeb:_____ Date:_____

Entered by:_____ Alumni Database:_____ Date:_____

Notification sent to: ❑JF ❑DC ❑KW ❑VC ❑LS ❑NP ❑CD ❑AE ❑MH ❑SM ❑HB

Notification type: ❑E-mail ❑Hard copy Date sent:_____ Initials:_____