



UC San Diego

HEALTH SCIENCES

Request for Trainee Name Change

Date _____

Program _____

Coordinator _____ Phone Number _____

Trainee Information

Current Name on File _____

New Name _____ Effective Date: _____

In accordance with UC San Diego Health Systems and the Office of Graduate Medical Education, I have complied with the following requirements necessary to request a name change for our program's trainee:

1. Trainee's name must be exactly the same with all of the following:
 - a. Social Security Card and PPS (in accordance with the University guidelines for name changes)
 - b. Medical/Osteopathic Medical Board of California
2. Without attaching the following documents, the name change request cannot be processed:
 - a. PPS printout reflecting new name
 - b. Copy of California Medical License with new name

Program Coordinator Signature

Date

Please send completed name change request to your OGME program representative.

Fax: (619) 543-2990.

Email: Tom Arneson: tarneson@ucsd.edu

Dion Brown: dibrown@ucsd.edu

Robyn Meehan, rmeehan@ucsd.edu,

For Office Use Only

PCIS _____ Epic _____

Benefits _____