Office of the Registrar
College of Medicine
University of South Florida
Phone: (813) 974-0828

560 Channelside Drive MDD 32
Tampa, FL 33602
Email: ComRegistrar@usf.edu

CHANGE OF NAME FORM

Student ID Number

FROM:

Last **First** **Middle**

TO:

Last **First** **Middle**

Reason for Change: Check appropriate box(es)

- ☐ MARRIAGE – Attach copy of marriage license/certificate
- ☐ DIVORCE – Attach copy of divorce decree
- ☐ LEGAL NAME CHANGE – Attach copy of court order
- ☐ OTHER – Attach Copy of substantiating document(s) and letter indicating reason

1. ARE YOU CURRENTLY ENROLLED? ☐ YES ☐ NO
2. ARE YOU A NEW STUDENT? ☐ YES ☐ NO
3. ARE YOU GRADUATING THIS TERM? ☐ YES ☐ NO

Local Address:

STREET CITY STATE ZIP CODE

Student's Signature _____ Date _____

Return completed form to: ComRegistrar@usf.edu

For Registrar Use Only: Data Updated
☐ MDB ☐ SRS Date:_____

CC: Business Office
Financial Aid
Student Affairs

Rev:01/20