



**HOFSTRA NORTHWELL  
SCHOOL of MEDICINE  
AT HOFSTRA UNIVERSITY™**

## Change of Name Form

Hofstra Northwell School of Medicine  
Office of Academic Affairs  
500 Hofstra University  
Hempstead, NY 11549-5000  
email: somregistrar@hofstra.edu  
phone: 516.463.7576

Instructions: Please type or print in ink. Upon completion, please **return this form to the Office of Academic Affairs, room 123**. This form must be accompanied by the documentation below AND your **Social Security card**. If you have any questions, please call **(516) 463-7576**.

I affirm that my name as currently recorded on the official Hofstra North Shore-LIJ School of Medicine record is:

First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

As if the date on this form, I wish my name on the official Hofstra North Shore-LIJ School of Medicine record to be changed to:

First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

for the following reason:

- Marriage (original certificate or copy must be shown)
- Divorce (original decree or copy must be shown)
- Other (appropriate documentation is required)

If other, state reason:

\_\_\_\_\_  
\_\_\_\_\_

Birth Date (mm/dd/yyyy): \_\_\_\_\_ Student ID (700#): \_\_\_\_\_

Street Address:

\_\_\_\_\_  
\_\_\_\_\_

Student Signature: \_\_\_\_\_

Date: \_\_\_\_\_