TEXAS DEPARTMENT OF LICENSING & REGULATION

P.O. Box 12157 • Austin, Texas 78711-2157

www.tdlr.texas.gov

DYSLEXIA THERAPIST AND DYSLEXIA PRACTITIONER NOTICE OF CHANGE AND DUPLICATE LICENSE REQUEST INSTRUCTIONS

PLEASE SIGN AND DATE THE FORM AND MAKE YOUR CHECKS PAYABLE TO THE TEXAS DEPARTMENT OF LICENSING AND REGULATION.

1. APPLICANT NAME – Provide your legal name in the spaces provided. (Last, First, Middle Name, Suffix) Examples of a suffix include Jr., Sr., and III. (Mr. is not a suffix.)
2. SOCIAL SECURITY NUMBER – Social Security Number disclosure is required by Section 231.302(c)(1) of the Texas Family Code in order to obtain a license. Your Social Security Number is subject to disclosure to an agency authorized to assist in the collection of child support payments. For more information regarding child support payments, contact the ***Texas Attorney General***.
   If you do not have a Social Security Number, you must complete the ***Social Security Number Status Certification*** form. See additional information at ***Verification of Lawful Presence***.
3. DATE OF BIRTH – Provide your birthdate.
4. LICENSE NUMBER – Provide your complete license number as it appears on your license.
5. DUPLICATE LICENSE REQUEST – Check the appropriate box if you want a duplicate of your license and include the $25.00 fee.
6. LICENSE TYPE THE INFORMATION NEEDS CHANGED ON – Check the appropriate boxes if you want to make changes to your name or contact information, such as your telephone number, mailing address, or email address.
7. NOTIFICATION: CHANGE MY NAME – Provide your new legal name in the spaces provided. You must submit a copy of the legal document approving or indicating your name change. If you want an updated copy of your license that shows your new name, you must submit the $25 duplicate license fee with this request. **(You must also return any previously issued license and renewal cards with your former name before the new license is issued.)**
8. NOTIFICATION: CHANGE MY MAILING ADDRESS – Provide your new mailing address in the spaces provided. This is the address where we will send you mail. This address can be a PO Box.
9. NOTIFICATION: CHANGE MY PHONE NUMBER – Provide your new phone number, including the area code.
10. NOTIFICATION: CHANGE MY EMAIL ADDRESS – Provide your new email address. Please provide your email address so the department may email license information and required notices to you. Your email address is confidential pursuant to the Texas Public Information Act, and the department will not share it with the public.
11. DATE AND SIGNATURE – Sign and date your request form. Changes to your record cannot be made if your request is not signed.

SEND YOUR COMPLETED APPLICATION AND REQUIRED DOCUMENTS TO:

TDLR
P.O. Box 12157
Austin, TX 78711-2157

Documents submitted with your application will not be returned. Keep a copy of your completed application, all attachments, and your check or money order. Do not send cash.

For additional information and questions, visit the ***TDLR website*** or reach Customer Service via ***webform.*** The webform will allow you to submit your request for assistance and include attachments needed. Customer Service Representatives are available Monday through Friday (excluding holidays) at (800) 803-9202 (in state only), (512) 463-6599, or Relay Texas-TDD: (800) 735-2989.

TDLR PUBLIC INFORMATION ACT POLICY:

This document is subject to the Texas Public Information Act. With certain exceptions, information in this document may be made available to the public. For more information, view the ***TDLR Public Information Act Policy***.

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DUPLICATE LICENSE FEE: $25.00 (FEE IS NON-REFUNDABLE)

PAYMENTS MUST BE IN THE FORM OF A CASHIER'S CHECK OR MONEY ORDER PAYABLE TO TDLR.

1. Name:

Last _____ First _____ Middle Name _____ Suffix _____

2. Social Security Number: _____

3. Date of Birth: _____ MM/DD/YYYY

4. License Number: _____

5. Duplicate License Request (place a check in the license requested) ($25 Fee Required)

☐ Therapist ☐ Practitioner

NOTIFICATION OF CHANGE ONLY

6. Your License type:

(You must submit a copy of the legal document approving or indicating your name change).

☐ Therapist ☐ Practitioner

7. Change my name: (see instructions)

Last _____ First _____ Middle Name _____ Suffix _____

8. Change my mailing address:

(P.O. Box, Number, Street Name/Apartment Number) _____ City _____ State _____ Zip Code + 4 _____

9. Change my phone number: _____

(Area Code) Phone Number

10. Change my email address: _____

(Ex: johndoe@gmail.com) See Instructions sheet for Disclosure)

11. Sign and Date:

The information which I have provided in this application is truthful and complete. I understand that providing false information of any kind may result in the voiding of this application, and my failing to be granted a license, or the revocation of my license.

Signature _____ Date _____