



**ORTHOTISTS AND PROSTHETISTS NOTICE OF CHANGE AND DUPLICATE LICENSE REQUEST INSTRUCTIONS**

**All information provided must be typed or printed in black ink.**

1. APPLICANT NAME – Write your legal name in the spaces provided. (Last, First, Middle Name, Suffix) Examples of a suffix include Jr., Sr., and II. (Mr. is not a suffix.)
2. SOCIAL SECURITY NUMBER – Social security number disclosure is required by Section 231.302(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 at:  
  
www.oag.state.tx.us/child/index or call (512) 460-6000 or (800) 252-8014
3. DATE OF BIRTH - Write your birthdate.
4. LICENSE NUMBER – Write 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 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 - Write 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.
8. NOTIFICATION: CHANGE MY MAILING ADDRESS - Write 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 - Write your new phone number, including the area code.
10. NOTIFICATION: CHANGE MY EMAIL ADDRESS – Write 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 - Date and sign your request form. Changes to your record cannot be made if your request is not signed.

**\*\*\* ACCREDITED FACILITIES MAY USE ONLY THIS FORM TO REQUEST A DUPLICATE \*\*\***

Changing ownership, or location of an accredited facility requires submission of the full application form and additional fees.



**Texas Department of Licensing and Regulation**  
 PO Box 12057 • Austin, Texas 78711-2157  
 (800) 803-9202 • (512) 463-6599 • FAX (512) 475-2871  
 www.tdlr.texas.gov • cs.op@tdlr.texas.gov

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 AND DUPLICATE LICENSE REQUEST**

DO NOT WRITE ABOVE THIS LINE			
<b>DUPLICATE LICENSE FEE: \$25 (FEE IS NON-REFUNDABLE)</b>			
<b>PAYMENTS MUST BE IN THE FORM OF A CASHIER'S CHECK OR MONEY ORDER PAYABLE TO TDLR.</b>			
1. Name:			
Last	First	Middle Name	Suffix
2. Social Security Number: <small>(See instruction sheet for disclosure information)</small>	3. Date of Birth:	4. License Number:	
	_____ Month      Day      Year		
5. Duplicate License Request (place a check in the license requested) (\$25 Fee Required)			
<input type="checkbox"/> Orthotist <input type="checkbox"/> Prosthetist <input type="checkbox"/> Orthotist/Prosthetist			
<b>NOTIFICATION OF CHANGE ONLY</b>			
6. License type the information needs changed on:			
<input type="checkbox"/> Orthotist <input type="checkbox"/> Prosthetist <input type="checkbox"/> Orthotist/Prosthetist			
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	
9. Change my phone number:	10. Change my email address:		
(      )      -      _____ <small>Area Code      Ph. Number</small>	_____ <small>(Ex: johndoe@gmail.com) See Instructions sheet for Disclosure</small>		
11. Date and Signature:			
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 of Licensee			Date Signed
<b>*** ACCREDITED FACILITIES MAY USE ONLY THIS FORM TO REQUEST A DUPLICATE ***</b> Changing ownership, or location of an accredited facility requires submission of the full application form and additional fees.			