



TEXAS DEPARTMENT OF LICENSING & REGULATION

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

www.tdlr.texas.gov

ORTHOTIC AND/OR PROSTHETIC FACILITY NAME CHANGE AND DUPLICATE LICENSE REQUEST INSTRUCTIONS

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

1. FACILITY NAME – Full legal name of facility. If doing business under another name, please explain on a separate sheet of paper.
2. BUSINESS PHONE NUMBER – Write the telephone number, including the area code, of the business listed
3. FAX NUMBER – Write a fax number, including the area code, where we can send you faxes.
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 \$25.00 fee.
6. YOUR FACILITY LICENSE TYPE – Check the appropriate boxes if you want to make changes to your facility name or contact information, such as your telephone number, mailing address, or email address.
7. NOTIFICATION: CHANGE FACILITY NAME – Write your new legal name in the spaces provided. You must submit a copy of the legal document approving or indicating the facility name change. The \$50 name change fee includes an updated copy of your license that shows the new facility name.
8. NOTIFICATION: CHANGE FACILITY MAILING ADDRESS – Write the new facility mailing address in the spaces provided. This is the address where we will send you mail. This address can be a PO Box. You cannot change the physical location of your facility with this form. Moving your facility to a new location requires an application for a new license.
9. NOTIFICATION: CHANGE FACILITY PHONE NUMBER – Write the new facility phone number, including the area code.
10. NOTIFICATION: CHANGE FACILITY EMAIL ADDRESS – Write the new facility email address. Please provide the facility email address so the department may email license information and required notices to you. The 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.

SEND YOUR COMPLETED APPLICATION AND REQUIRED DOCUMENTS TO:

Texas Department of Licensing and Regulation
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 you check or money order. Do not send cash.

For additional information and questions, please visit the Texas Department of Licensing & Regulation website at <https://www.tdlr.texas.gov> or reach Customer Service via webform where you can submit your request for assistance and include attachments as needed at <https://www.tdlr.texas.gov/help>. Customer Service can also be reached at (800) 803-9202 [in state only], (512) 463-6599, Relay Texas-TDD: (800) 735-2989 or Fax: (512) 463-9468. Customer Service Representatives are available Monday through Friday 7:00 a.m. until 6:00 p.m. Central Time (excluding holidays).

ACCREDITED FACILITIES MAY USE THIS FORM ONLY TO REQUEST A DUPLICATE LICENSE OR FACILITY NAME CHANGE

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



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DO NOT WRITE ABOVE THIS LINE

DUPLICATE LICENSE FEE: \$25 (FEE IS NON-REFUNDABLE)
FACILITY NAME CHANGE FEE (INCLUDES DUPLICATE): \$50 (FEE IS NON-REFUNDABLE)

1. Facility Name:

2. Business Phone Number:

3. Fax Phone Number:

4. License Number:

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

Orthotic Facility Prosthetic Facility Orthotic/Prosthetic Facility

FACILITY NAME CHANGE

6. License type (place a check the license requested) (**\$50 Fee Required**):

Orthotic Facility Prosthetic Facility Orthotic/Prosthetic Facility

7. Change facility name: (see instructions)

8. Change facility mailing address:

(P.O. Box, Number, Street Name/Apartment Number)

City _____ State _____ Zip Code _____

9. Change facility phone number: 10. Change facility email address:

()
Area Code Ph. Number

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

11. Date and Signature:

The information on this application is true and correct. I understand that providing false or misleading information in, with, or concerning this application may be cause for denial or loss of accreditation. I understand that knowingly providing false information on a government document is punishable by a state jail felony.

Signature of Licensee _____

Date Signed _____

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