Wyoming Department of Health

Name and Address Change Form

Please complete this form and return it to the Provider Support Staff for your area.

Provider Name (as currently certified):_____

☐ No Changes

Name Change	
Last:	First:
Business Name:	☐ N/A

Address Change		
Street Address:		
PO Box:		
City:	State:	Zip:
☐ Physical		☐ Mailing

Email Address Change
Email Address:

Phone Number Change		
Phone Number:		
☐ Mobile	☐ Home	☐ Business

Other Changes

Signature:_____ Date:_____