

# CHANGE OF ADDRESS OR CHANGE OF NAME

## For hearing aid program only

Send the following information, within 10 days of change, to:

**Pennsylvania Department of Health**

**Hearing Aid Program**

**555 Walnut St, 7<sup>th</sup> Floor Forum Place**

**Harrisburg, PA 17101**

**Phone: (717) 787-4779, email [ra-communityprogramlicensure@pa.gov](mailto:ra-communityprogramlicensure@pa.gov)**

**Fax: (717) 787-3188**

NAME CHANGE: If change of business name is result of change of ownership, a new application must be submitted. If this is change of individual name, please provide government issued ID reflecting new name.

**CERTIFICATE NO.** \_\_\_\_\_

**OLD ADDRESS:**     **HOME**    **BUSINESS**    **BRANCH**

Name: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_

## NEW ADDRESS

Name: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Effective date: \_\_\_\_\_