Stony Brook University

Request to Change Primary (Legal) Name

- Requires at least TWO VALID and ORIGINAL forms of Identification (see choices below)
- Both forms of the required identification must show the NEW name
- At least ONE form of required identification must be a photo ID

<table>
<thead>
<tr>
<th>Last Name (Current Name on SB Records)</th>
<th>First Name (Current Name on SB Records)</th>
<th>Stony Brook ID (as indicated on your Stony Brook ID card)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Phone number with area code</td>
<td>Daytime (work) phone with area code</td>
<td>Today's Date MM / DD / YYYY</td>
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<td>( ) -</td>
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</tbody>
</table>

NEW LAST NAME (family name)

NEW FIRST NAME

NEW MIDDLE NAME or MIDDLE INITIAL

Are you CURRENTLY an EMPLOYEE at Stony Brook University?  
If you are a GA or TA or RA, you qualify as an employee.  
If you are a current employee, enter your Social Security Number  

If current or former employee, complete the entire form and submit to Human Resources, Administration Bldg., Room 390. Bring a Social Security Card reflecting the NEW name.  
Current Employees with Health Insurance must also speak to a representative in Benefits.

Are you CURRENTLY a STUDENT at Stony Brook University?  
Are you in an East Campus Health Science program?  
Are you a degree candidate?  
If YES, enter the TERM and YEAR you expect to graduate  

If your ONLY status is STUDENT, complete this form and submit to:  
Stony Brook University, Office of the Registrar, Administration Bldg., Room 276 Stony Brook, NY 11794-1101  
***HSC Students: submit form to HSC Office of Student Services, Level 2, Room 271 Stony Brook, NY 11794-8276***

STUDENT/EMPLOYEE SIGNATURE ___________________________ DATE ________________________

OFFICE USE ONLY

TWO ID’s REQUIRED:
- at least one photo ID
- copy the submitted ID’s for files

- Driver’s License
- Divorce/Marriage Certificate
- Court Action
- I-20
- Social Security Card……….. Required for Employees
- Passport………………………… Required for non-US citizens
- Professional License…………….. Required for Health Care Employees

Stamp Date Received

Date of on-line update

Staff Member Initials