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

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.

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 – Provide the telephone number, including the area code, of the business listed
3. FAX NUMBER – Provide a fax number, including the area code, where we can send you faxes.
4. LICENSE NUMBER – Provide your complete license number as it appears on your license.
5. DUPLICATE LICENSE REQUEST – Select the appropriate box if you want a duplicate of your license and include the $25.00 fee.
6. YOUR FACILITY LICENSE TYPE – Select 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 – Provide 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 – Provide 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 – Provide the new facility phone number, including the area code.
10. NOTIFICATION: CHANGE FACILITY EMAIL ADDRESS – Provide 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. ACKNOWLEDGEMENT – Date and sign your request form. Changes to your record cannot be made if your request is not signed.

SEND YOUR COMPLETED REQUEST AND REQUIRED DOCUMENTS TO:

TDLR
P.O. Box 12157
Austin, TX 78711-2157

Documents submitted with your request will not be returned. Keep a copy of your completed request, all attachments, and your check or money order. Do not send cash.

For additional information and questions, please visit the ***TDLR website***. You can request assistance or submit required attachments via ***TDLR webform*** or fax (512) 475-2871. You may contact Customer Service Representatives by calling (800) 803-9202 (in state only) or (512) 463-6599; Relay Texas -TDD (800) 735-2989. Customer Service Representatives are available Monday through Friday (excluding holidays).

TDLR Public Information Act Policy:
This document is subject to the Texas Public Information Act. With certain exceptions, information in this document may be made available to the public. For more information, view the ***TDLR Public Information Act Policy***.

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THIS COMPLETED FORM MUST BE ACCOMPANIED BY ALL REQUIRED DOCUMENTS.

DUPLICATE LICENSE FEE: $25.00

FACILITY NAME CHANGE FEE: $50.00 (INCLUDES DUPLICATE)

(ALL FEES ARE NON-REUNDABLE)

1. Name of Facility:

2. Business Phone Number:	**3. Fax Phone Number:**	**4. License Number**
(Area Code) Phone Number	(Area Code) Phone Number	

5. Duplicate License Request: (Select the license type your requesting) **($25 Fee Required)**:

☐ Orthotic Facility ☐ Prosthetic Facility ☐ Orthotic/Prosthetic Facility

FACILITY NAME CHANGE

6. License Type: (Select the license type your requesting) **($50 Fee Required)**:

☐ Orthotic Facility ☐ Prosthetic Facility ☐ Orthotic/Prosthetic Facility

7. Change Facility Name To: (See instructions for documentation you will need to submit)

8. Change Facility Mailing Address:

P.O. Box, Number, Street Name, Suite Number/Apartment Number | City | State | Zip Code

9. Change Facility Phone Number:	**10. Change Facility Email Address:**
(Area Code) Phone Number	See Instruction Sheet for Disclosure Information

11. ACKNOWLEDGEMENT

The information on this request is true and correct. I understand that providing false or misleading information in, with, or concerning this request 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 person completing this form | Date Signed

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