



**ARKANSAS INSURANCE DEPARTMENT
FUNERAL SERVICES DIVISION | EMBALMERS & FUNERAL DIRECTORS**

REQUEST FOR NAME CHANGE | Type A, B, C, and D

IMPORTANT: The way you list the **name, city, county,** and **state** in this section will be how those items will appear on the license.

New Name of Establishment _____

City and State: _____ **County:** _____ **Board ID:** _____
City State

Include a fee of \$20

Previous Name of Establishment: _____

Phone Number: (____) _____ **Fax Number:** (____) _____

E-Mail Address: _____

Applicant's Physical Address:

Number/Street City State ZIP Code County

Applicant's Mailing Address: [If different from the Physical Address listed above]

Number/Street/P.O. Box City State ZIP Code County

I hereby certify that all information and statements contained within this application are true, to the best of my knowledge and belief.

Manager/Owner Signature

Application Date

NOTARY PUBLIC:

[Notary Stamp or Seal]

State of _____

County of _____

Subscribed and sworn to before me this _____ day of _____, 20 _____.

Notary Public Signature

Commission Expiration Date

Mail Completed Application To:

Arkansas Department of Commerce
Arkansas Insurance Department | Funeral Services Division
1 Commerce Way, Suite 502 | Little Rock, AR 72202-2082
Phone (501) 682-0574 | Fax (501) 682-0575
E-Mail: AID.EFD@arkansas.gov

Reason for Name Change, use box below. Please provide a copy of your business license that verifies the name change.
