



CHANGE OF ADDRESS FORM

Return to the Office of the Registrar
74 King Street • St. Augustine, FL 32084

FULL NAME: _____ STUDENT ID#: _____
Last First MI

SOCIAL SECURITY NO: _____ BIRTH DATE: _____

NEW ADDRESS

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE: Cell (____) _____ Home (____) _____

FLAGLER COLLEGE BOX NUMBER IS NOT ACCEPTABLE

CHANGE APPLIES TO: *(check all that apply)*

- | | |
|---|--|
| <input type="checkbox"/> Local Address | <input type="checkbox"/> Permanent Address |
| <input type="checkbox"/> Parent Address | <input type="checkbox"/> Billing Address |

NEW ALTERNATE EMAIL _____ @ _____
(other than Flagler Email)

STUDENT SIGNATURE: _____ DATE: _____

ANTICIPATED GRADUATION DATE: _____
MM/YYYY

NAME CHANGE *(Legal documentation is required when changing your name)*

NEW NAME *(Print)* _____
First Middle Last

OFFICE USE ONLY:

COPY: Business Services

College Nurse *(Name Change Only)*
Alumni Affairs *(Alum Only)*

Box 1393
Box 1392