pennsylvania
DEPARTMENT OF BANKING
AND SECURITIES

DEBT MANAGEMENT SERVICES
CHANGE OF STATUS OF CERTIFICATION FORM

A licensee who has any changes in its status regarding the licensees' certified credit counselors, supervisors or managers with direct supervisory duties of credit counselors shall notify the Department in writing **within ten (10) days** of the change. Mail the original to the address listed above or you may fax a copy to the fax number below. Please list the information on the individual whose information is being changed in the spaces provided below. Attach additional sheets if necessary.

Individual Name: _____

Title: _____ **Hire Date:** _____

Work/Office Address: _____

_____

Certifying Organization/Association (if applicable): _____

Check the applicable item *AND* provide a brief explanation in the Additional Information section:

Certification Completed: ☐

Certificate Number: _____ **Expiration Date:** _____

Certification Revoked: ☐ **Change in Employment:** ☐ **Other:** ☐

Additional Information: _____

_____

_____

Effective Date of Change: ____/____/____

Signature and Title of Authorized Person (Control Person) for Licensee

Company Name: _____ **License #:** _____

_____ _____
Printed Name of Authorized Person (control person) Title

I affirm that the statements contained in this form are true and correct.

_____ _____
Signature of Authorized Person (control person) Date