NABP
National Association of Boards of Pharmacy
www.nabp.pharmacy

1600 Feehanville Drive
Mount Prospect, IL 60056
T) 847/391-4406
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Name Change Granted by a Foreign Government Agency

For security reasons, documents can only be submitted to NABP via mail.

Complete and hand sign this form in front of a notary and make a copy for your file. **Please type or print legibly. Mail** this signed and notarized original, along with a **photocopy of your name change documentation** (marriage license/certificate, divorce decree, or court ordered name change document) to NABP Customer Service. Please refer to the CPE Monitor FAQs on the NABP Website for translation procedures on non-English documentation.

Your Current Name: _____ _____ _____ **Date of Birth:** _____

Your Signature: _____ **NABP e-Profile ID:** _____ (if applicable)

Pharmacist/Technician License No.: _____ **State:** _____ (if applicable)

Mailing Address: _____

Phone Number: _____ **Email Address:** _____

Former Name: _____

New Name: _____ _____ _____

Reason for Change: _____

Applicant/Licensee:
I request that the information in my NABP e-Profile be changed as I indicated on this form. I affirm that the information provided on this form, and submitted in connection with this form, is true, correct, and complete. I understand that if false or misleading information is provided in, or in connection with, this form, NABP may elect to pursue any and all available remedies including, but not limited to, suspension or termination of my NABP e-Profile ID or referral of the matter to regulatory, government, or law enforcement authorities.

Notary:
State of _____ County of _____

I certify that on _____ (day) of _____ (month), _____ (year),

_____ (name of affiant) personally appeared before me, and is personally known to me or proved to me on the basis of a current official federal or state government photo identification to be the individual whose name is subscribed on this form and acknowledged to me that he/she has executed this form and attested that the statements made by him/her on this form are true, correct, and complete and all supporting documents in connection with this form are true, correct, and exact copies of the official record maintained by the designated governmental body.

Notary Public signature _____ **Notary Stamp**

Notary ID number _____

Expiration date _____/_____/_____
Month Day Year

Mail to: National Association of Boards of Pharmacy
Attn: Customer Service
1600 Feehanville Drive
Mount Prospect, IL 60056-6014