
CHANGE OF ADDRESS

Name _____ License/Registration No _____

NEW ADDRESS

Street _____
City _____ State _____ Zip _____
E-mail Address _____ Home Phone _____

PREVIOUS ADDRESS

Street _____
City _____ State _____ Zip _____
Home Phone _____

Date Change Effective _____ Signature _____

CHANGE OF EMPLOYMENT

Name _____ License/Registration No _____

NEW PLACE OF EMPLOYMENT

Pharmacy Name _____ KY Pharmacy Permit No _____
Street _____
City _____ State _____ Zip _____
Position _____ Phone _____
(e.g., staff, pharmacist-in-charge, etc.)

PREVIOUS PLACE OF EMPLOYMENT

Pharmacy Name _____ KY Pharmacy Permit No _____
Street _____
City _____ State _____ Zip _____
Position _____ Phone _____
(e.g., staff, pharmacist-in-charge, etc.)

Date Change Effective _____ Signature _____

PLEASE COMPLETE AND MAIL OR FAX TO:

Kentucky Board of Pharmacy
State Office Building Annex, Suite 300
125 Holmes Street
Frankfort, KY 40601
Phone 502-564-7910 Fax 502-696-3806