Please fill out the change of address form below and fax or mail to:

Department of Health
Bureau of Statewide Pharmaceutical Services
4052 Bald Cypress Way, Bin #C-04
Tallahassee, Florida 32308
Fax (850) 413-6982

ADDRESS CHANGE FORM

CERTIFIED DESIGNATED REPRESENTATIVE

Please type or print in the appropriate spaces below if you have a change of address correction.

NAME:_____

EXAMINATION DATE:_____

PHONE NUMBERS:_____
Area Code/Number **Area Code/Number**

OLD ADDRESS:_____

_____

NEW ADDRESS:_____

_____

SIGNATURE:_____

NOTE: If your name has changed, please use your prior name on this form and contact the Bureau for name change or name correction information.